IN THE PROVINCIAL COURT

OF

NEWFOUNDLAND AND LABRADOR

The Honourable Donald S. Luther

16 December 2003

REPORT OF INQUIRIES

INTO THE SUDDEN DEATHS OF

NORMAN EDWARD REID

DARRYL BRANDON POWER

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106-02636/

I. Executive Summary

The health, social and justice systems failed Norman Reid and Darryl Power. That they allowed these men to arrive at the life and death situations of August 26, 2000, and October 16, 2000 respectively, is a tragedy of enormous proportion.

There are many reasons why these governmental systems failed including a lack of meaningful response to the concerns and recommendations of the May 1980 Judicial Inquiry into the sudden death of Thomas Hagan.

The provision of fragmented services proved nugatory. Generally, service providers did what was required of them to an acceptable level most of the time but lack of a co-ordinated effort was sadly demonstrated. The issue here was not financial. There was an enormous amount of funds, hundreds of thousands of dollars, expended on behalf of these two men, yet to no avail. With mentally ill persons who have shown themselves to be dangerous from time to time, to shore up a façade of personal rights and freedoms at these costs in terms of human misery and lost opportunities was highly questionable.

Mental Health legislation has not been updated since its inception in 1971. Mental health practices outside St. John's have been only somewhat improved over this time period. Most progress has been isolated and piecemeal. Our province, to its utter shame, has by far the oldest *Mental Health Act* in the country.

The failure by successive governments since the early 1980's to enact new Mental Health legislation is inexcusable. The apologists can be as articulate as they like and can boldly serve up all kinds of reasons why the old law remains in effect year after year after year.

> "It can be seen from the opposing advocacy positions described above that it is unlikely there will ever be consensus on the major issues in mental health legislation. Policy makers must be aware of these positions and the needs of people with severe mental illnesses for services and to be treated with dignity. In addition, policy makers must have a scientific understanding of the mental illnesses that are likely to result in the need for involuntary services. Also, the scientific methods of alleviating the suffering, restoring functioning and reducing harm caused by untreated severe mental illnesses must be noted."[1]

It was as if another killing had to take place before those responsible would exercise leadership and do what so desperately needs to be done.

Both men were caught in a downward spiral toward disaster, which the societal safeguards, such as they were, could not or would not prevent.

There would not have been judicial inquiries nor such major multi-police force investigations if Norman Reid and Darryl Power had been only wounded. But that would be to lose sight of the larger more important issue as to why these two men reached this point in their lives.

One might be tempted to suggest that the greater tragedies were the wretched and tormented lives of these men as opposed to their sudden deaths. Indeed, the argument could be advanced that either or both would have died prematurely in any event through violent means or further sickness or disease brought about by neglect and untreated health issues.

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[1] John E. Gray, Margaret A. Shone and Peter F. Liddle, *Canadian Mental Health Law and Policy*, (Toronto: Butterworths 2000) at 66.

It is only because Norman Reid and Darryl Power died as a result of being shot by police officers that we have painstakingly looked into their lives and deaths. If they had died in a fire or from hypothermia or almost any other cause, their lives would be publicly marked by at most a short obituary notice. It is almost as if these type of deaths had to take place before meaningful widespread reform would occur.

If the purpose of my recommendations were simply to avoid situations where police shoot and kill mentally ill persons, we could quite simply focus on the technology of intermediate weapons and better defensive gear for those police officers responding in crisis situations.

However, it would be a futile exercise to bring about more effective police responses so that mentally ill persons can be stopped but not killed, unless we as a society can better deal with the underlying problems represented all too well in these Inquiries.

The recommendations of these Inquiries are specific. In many instances, time frames are attached so that those who are the subject of the recommendations will be clearly accountable to the people of Newfoundland and Labrador and the recommendations will be either accepted or rejected in a timely fashion.

The police responses in both situations fell somewhat short of perfection. Clear, strong and convincing evidence does show that both the R.C.M.P. and R.N.C. met professional policing standards in their crisis responses to Norman Reid and Darryl Power. We have examined both shootings in as detailed a fashion possible and, with the benefit of virtually unlimited hindsight, various shortcomings have been documented. While neither response was perfect, they were both understandable and consistent with well developed national and provincial police training and standards.

Through both investigations the involvement of the O.P.P., including their members' evidence at the Inquiries, was very helpful to the people of Newfoundland and Labrador.

The public of our province does not accept the police investigating themselves in deaths caused by officers on duty. As such, the timely utilization of an outside force, such as the O.P.P., goes a long way to dispel the notion of partiality and favourable treatment.

Engaging a well recognized and respected outside police force has nothing to do with the professionalism and competence of local police officers or their force as a whole. Rather, it is specifically designed to remove any reasonably perceived notion of partiality or cover-up.

The police shooting deaths of two mentally ill men within a period of 51 days is unprecedented in the history of Newfoundland and Labrador. That fact, coupled with the high value on human life cherished by the people of this province, has created an unusually high public interest in these tragedies.

The inquires were ordered by the Minister of Justice pursuant to s. 26 of the *Fatalities Investigations Act*, 1995, S.N.L. c. F-6.1, and were conducted according to *Part*

IV of the Provincial Offenses Act, 1995, S.N.L. c. p-31.1 and other relevant provincial legislation.

Throughout the Inquiries, all relevant witnesses were heard and both families were well represented by competent counsel. Standing was generously afforded to interested parties. A careful examination of the transcripts and exhibits, the extensive media coverage, and the availability of inquiry counsel and liaison officers before and during the Inquiries must surely eliminate any suggestion of less than a full and open public inquiry.

Necessarily, there was considerable cost to the Inquiries. During the course of the two Inquiries, we heard or received evidence from 167 witnesses over the course of 129 days, from February 2, 2001 to December 16, 2002. Final arguments were presented in March 2003. The sittings of the Inquiries were in Bonavista, Corner Brook and St. John's. Judicial views were taken in Little Catalina and Corner Brook.

In a free and democratic society, it is essential that the judiciary does all that is reasonably expected of it to promote and maintain public confidence in the administration of justice. It is hoped that public expectations have been met by the substantial efforts of all concerned during the course of these two Inquiries.

PART 1 - NORMAN REID

1. Factual Review

1.1 Norman Reid

a. Family

Norman Edward Reid was born on January 22, 1957, and died tragically on August 26, 2000, at Little Catalina, Newfoundland and Labrador. He was the third of the ten children of Mary Jane Reid and Robert Lesley Reid. There were five daughters and five sons.

As was fairly typical of life in rural Newfoundland in the 1950's and 1960's, life was not always easy; however, there was generally enough food to get by and a house to come home to. Roberta Abbott, a sister of Norman Reid, described Christmas time for the family: "although you didn't get much, if you got one thing, you were always grateful for that one gift. Christmas was seen as a time to get fruit. If you got fruit in your stocking, that was a treat."

Mary Jane Reid was a devoted housekeeper. Robert Lesley Reid throughout his working life was a woodcutter, shipbuilder and fish plant carpenter. There were numerous chores for family members so that basic needs were met. These included cutting wood, hauling water, caring for animals and tending to the garden.

They were seen as a "rough and tumble" family perhaps as a result of the accounts of physical fights and arguments involving some of the brothers including Norman Reid. There were incidents of violence which spilled over into adulthood, many of which involved Norman Reid particularly after he became mentally ill.

Family members struggled with what to do for and about Norman Reid. Often, food was prepared for him and was rejected. On other occasions, he would arrive, for example, at Roberta Abbott's, have his clothes washed and a bath. His brother, Bill, helped him purchase a car. Another brother drove him to the General Hospital in St. John's in March 1978, his first and only voluntary admission to a hospital for mental health concerns.

With the prolongation of the illness and the increased severity of symptoms manifesting, including violence, this rural Newfoundland family of limited education were largely stymied to the point that Norman Reid's most consistent care giver, Dr. Norman, observed that there was a strained relationship between Norman Reid and the family. Dr. Norman never got the sense that the family was supportive.

In reviewing the social work files of the Waterford Hospital, Glenda Webber, M.S.W. stated that there was only one time that a family member was present with Norman Reid and that from her perspective it would have been better to have had more face to face contact with the family.

b. Community

Little Catalina is a small community which is approximately 13 kilometers from Bonavista. Largely as a result of the cod moratorium of the early 1990's, Little Catalina's population had declined to a total of 528 in 2001 from 774 in 1986 and the unemployment rate was more than 50 percent higher than the provincial average.[2]

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[2] An informative history of Little Catalina is found in Inquiry Brief, Vol. 1, at 39-42, David Day, Q.C.

There was general acceptance of Norman Reid in the community while he continued to live with his family; however, as Norman Reid became mentally ill and behaved erratically, things changed especially after he moved into his uncle's home by himself in 1991.

As time progressed, certain members of the community started to regularly taunt, harass and ridicule Norman Reid whom they no longer understood or cared about.

In her brief on behalf of the Canadian Mental Health Association, Sandra Burke wrote at page 15:

> "All witnesses knew Norman had an illness called schizophrenia, but virtually everyone (including police officers) said, "I don't really know anything about it." Those who remembered Norman as a boy appeared to have a sense of him as an individual; they tended to be more compassionate and less likely to regard him with fear. Those who knew him only from his external appearance and the stories they heard often saw him as strange and frightening. There were suggestions that among some youth in the community he was seen as a kind of "boogie-man" whom it was a challenge to taunt or tease.
>
> Generally, there was a sense that Norman's illness made his behaviour unpredictable, and a fear of potential violence, fueled by reports of his verbal threats to certain individuals that he would "kill" them, or "slit their throats." Some people testified to locking their doors at night specifically because of Norman. While many people said they had never witnessed any physical altercations or problem behaviour on his part, even those who said they were not afraid of him also said, "you never knew what he might do."
>
> The quite lengthy periods when Norman's health was stable seem to have passed without any incidents of note. The problems arose when he became ill, and these episodes occurred with greater frequency after 1994, and in the last two years of his life. By then there was universal agreement that Norman represented a problem in the community. Some witnesses saw this as the responsibility of the authorities; some felt the family should play a more active role; some expressed a sense of guilt that they had not done more

> themselves. However, no one knew what to do, other than call the police and have him taken to the Waterford Hospital."[3]

c. Employment and Education

Norman Reid left school in 1977 at the age of 19, part way through Grade XI, only a few months from possibly graduating from high school. His interests included body building, cooking, boat construction and carpentry. Perhaps somewhat ahead of his time in terms of health issues, Norman Reid was strongly opposed to smoking to the point of chastising his brother and father for continuing in the habit. He was also known to have prepared stir-fried nutritional meals.

Norman Reid left school to work at the Little Catalina fish plant. He sporadically worked there and at local social services community projects until the mid to late 1980's when Dr. Gallimore described him as "chronically and permanently disabled." Mental illness seriously affected his education and employment.

d. Health

i. Onset of Mental Illness

Norman Reid appeared to have exhibited symptoms of mental illness in his late teens. He started consuming alcohol, on many occasions to excess, and experimented

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[3] Sandra Burke, Inquiry Brief, at 15.

....../Onset of Mental Illness

with LSD and marijuana - perhaps as a form of self medication to deal with the internal turmoil.

> "It was when Norm turned 18 years old that things started to change and his actions and personality started to show signs of different behavioral patterns. Family members associate the changes with the occurrence of Norm purchasing a car. At the time, Norm was the envy of all his peers and, as a result, the typical pressures of being a teenager started to be felt. It was at this time that Norm first experimented with alcohol and drugs, marijuana in particular.
>
> Further changes in Norm's behaviour became noticeable when he subsequently had a serious motor vehicle accident, totally demolishing the car. Devastated, it was at this time that his life started to take on a drastic change for the worse. Not only was he enduring the general pressures of being a young adult, he was now being isolated and ignored by his friends because he no longer had the attraction which had made him so popular.
>
> In the words of Norm's sister, Roberta Abbott,
>
> **"Q. Okay. And that would coincide with your recollection of when he first showed signs of becoming ill?**
>
> **A. Yes.**
>
> **Q. Okay. And the particular incident, I take it, that sticks out in your mind is it's around the time that he lost his vehicle?**
>
> **A. Well. Yeah. That's when things really got bad because the way I - like my view is that that's when his life changed because here he was, now he was having these problems - I guess, like you said, he was experimenting with drugs - from my understanding, you know, that's what was going on and he beat up his car and like in a blink of an eye now here he's got his car gone, he's got his friends gone, because they don't want to be around him anymore because he don't have his vehicle anymore, and more or less they used him, you know, and now that he was sick, you know.**
>
> **Q. So everything seemed to come to a, to a peak?**

> **A. Yes."[4]**

> "Some of the early symptoms of illness that Norm displayed were his becoming agitated with small things such as appliance noises and the like. The family would often wake in the morning to find the fridge and stove unplugged because Norm would find that the noises bothered him."[5]

> "More ominous were experiences he reported as having occurred during employment at the Little Catalina fish plant in January and February 1978. They were summarized in a Discharge Report prepared by psychiatry resident Dr. D. M. Bhide at Waterford Hospital, on 12 June 1978 [Exhibit DV #1, tab 1, p. 1]:

> .... While working, he felt that people were talking about him behind his back, making nasty remarks, and accusing him of being a homosexual. He heard them saying, "Let's see what he is and what he is made of," "he must be a queer," and "he is no good." These comments made him very upset, and the thought that all these things were done on purpose to tease and frighten him. Then he heard his colleagues saying, "he is a fag," and he also felt that his colleagues wanted to harm him. He believed that his "inner conscious has awakened and the awakening of the inner conscious is a Gift of God." He said that now he has ["] an open conscious ["] and he is sharing ["] the inner conscious ["] of a next door neighbour and they are controlling each other's thoughts and actions. He started hearing voices around last week of February [1978] calling him a homosexual."[6]

ii. Local Doctors and Nursing Care

Norman Reid was treated by a number of local doctors on the Bonavista Peninsula for a number of unrelated medical concerns (ulcer, foot, back, dentures, cough, diarrhea, bruised ribs, eczema, cut on arm). There was quite a turnover of medical staff in the region and he was never examined by a resident psychologist or psychiatrist in Bonavista at that time.

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[4] *Ibid.* at 15.

[5] Thomas E. Williams, Inquiry Brief, at 8-9.

[6] David C. Day, Q.C., Inquiry Brief, at 45-46.

Dr. Gallimore was his principal doctor from the late 1970's until 1988, while Dr. Norman treated him frequently and regularly between 1989 to 1994. Both developed a relationship of trust with their patient. Dr. Gallimore regularly picked him up on the road and gave him rides. Dr. Norman, who had grown up in Port Union, knew Norman Reid as someone who respectfully referred to him as "Doctor" rather than by his first name. Neither doctor was fearful of Norman Reid and both felt they were treated with respect by their patient, even though he was constantly inquiring as to the necessity of taking his medications, particularly Modecate and Haldol. Both local doctors recognized that a case management team would have been beneficial.

The health care system was "somewhat fragmented" where discharge reports from the Waterford Hospital would sometimes arrive to their office four weeks later.

Dr. Norman realized that when Norman Reid returned to Little Catalina from the lockup he was in crisis and in need of more help than he as a family practitioner could offer. Nonetheless, during the numerous visits, Dr. Norman took the time to develop a good relationship with his patient, discussing many important issues to Norman Reid including the Bible, work, his father's death, and finances. Norman Reid never complained to Dr. Norman or Dr. Gallimore about how the R.C.M.P. treated him. Interestingly enough, Dr. Norman was aware of the time he spent with this needy patient and felt that if he spent "too much time," it would be a red flag for a potential MCP audit.

There was a consistent pattern of 13 involuntary admissions to the Waterford Hospital (11 therapeutic, 2 forensic) with discharges. Norman Reid would always become well enough to go home, i.e. no longer certifiable. However, he regularly relapsed largely as a result of his unwillingness, for a number of reasons, to take his medications as prescribed.

Dr. Norman explained Norman Reid's unwillingness to take his medications by pointing out that a person suffering from schizophrenia does not accept that he is mentally ill. Realizing that people might see him as mentally ill, one of the ways of proving that he was not was to cease taking his medication. In other words, if you take your medications you are confirming to others that you are mentally ill.

The only prolonged times of relative wellness occurred when Norman Reid voluntarily took long-acting injections from Dr. Norman and by Court Order from the Public Health Nurse, primarily Sheila Hancock, who also expressed no fear of Norman Reid.

Nurse Hancock provides considerable insight into Norman Reid's life in the 1990's as result of her 28 visits to his home and her considerable experience. A useful summary is contained in the C.M.H.A. brief by Sandra Burke:

- "She made initial contact with Norman's brother and mother, but saw no evidence of active support other than very basic contact. Norman told her "They got no time for me."
- His bungalow was dilapidated and very cold.
- Norman was a heavy smoker who took no exercise and was at risk of malnutrition. After he received his cheque, he would buy cigarettes and pay bills and have very little left for food.

- He knew he was told he had schizophrenia but said the medication caused his problems. He didn't want to hear any education, saying there was nothing wrong with him.

- Although he showed no insight into the illness, Norman understood the effects of the medication prescribed to him. He was vigilant regarding the dosage of Haldol, watched her draw it up, and would not accept more than 75 ml. At one point he asked her about Modecate as an alternative. He accepted only half the Haldol dosage in November 1998 and refused it altogether in December, at the end of the probation period. However, he managed his Cogentin (to control side effects) consistently and would call her to get the prescription renewed.

- Norman was always courteous to her and cooperated during her visits, giving her no cause for concern. She would spend anything from 10 to 45 minutes with him, depending on his mood.

- He struck her as a troubled, secretive man. He knew people were afraid of him and ostracized him. Children taunted and jeered at him, and Norman told her their parents would come out and curse him, telling him to go on. He was always alone.

- The times he was agitated often coincided with confrontations in the community.

- Ms. Hancock had ongoing communication with the Probation Officer and found him very helpful. Communication with other services was much more difficult.

- Getting Norman's medical order varied was very difficult. Dr. Ladha advised her to have him brought in by the R.C.M.P., which she felt was too drastic. She tried without success to coordinate a change through Dr. Norman. She managed to persuade Norman to accept a voluntary appointment with Dr. Ladha, but he slept in and missed it. Dr. Ladha's secretary refused to make another appointment without a referral from Dr. Norman.

- Ms. Hancock attempted to have improvements made in Norman's financial and housing situation and both visited and wrote a letter to the then Social Services office in Bonavista in 1996. She could not find out what was available to him and was frustrated by the apparent rigidity of the regulations.

- She felt he would have benefitted from social work services, and that he needed consistent support from a patient, nurturing person.
- In her recommendations, Ms. Hancock emphasized the need for proactive coordination of services, with contact between hospital and community services both before and following discharge. She saw case management as imperative, encompassing nutrition, help with financial management, family education and access to employment.
- In conclusion, Ms. Hancock stated, "Norman Reid was not a monster. He was a victim of mental illness and circumstances."[7]

iii. Psychiatrists and Waterford Hospital

It is outside the scope of this Inquiry to review and critique psychiatric and institutional policies and practices of the 1970's, 1980's and 1990's.[8] It is the purpose of the Inquiry to recommend changes to existing policies and practices with a view to significantly reducing, if not virtually eliminating the possibility of another medical history such as that of Norman Reid. With this in mind, there will not be a detailed analysis of every admission to the Waterford Hospital[9], rather what follows is a brief commentary serving to outline the extent of the deterioration in Norman Reid's mental health and the increased danger he was posing to others.

Dr. Ladha, a psychiatrist at the Waterford Hospital, was called on to testify twice at the inquiry. He talked of common threads:

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[7] Sandra Burke, Inquiry Brief, at 28-29.

[8] Thomas E. Williams, Inquiry Brief, at 12-16, shows some possible shortcomings in healthcare in 1978.

[9] Nicholas Avis, Q.C., Inquiry Brief, at 9-12.

- "never admitted as a voluntary patient
- extensive use of R.C.M.P. because of his aggressive and violent behaviour
- many threats were toward family members"[10].

For example, concerning the fourth involuntary admission (January 10, 1980 to February 7, 1980) Norman Reid's discharge report stated that, "he is said to have stopped taking his medication and had become violent and aggressive. He tried to choke his brother to death and tried to kill a cat by setting it on fire.".

Further, the 12th admission (September 9 to November 29, 1999) was preceded by a violent confrontation with the R.C.M.P. involving his use of sticks as weapons. During this stay, Norman Reid was placed in the Therapeutic Quiet Room at least five times. It was again obvious that he was unlikely to take his medications upon discharge.

Norman Reid was becoming familiar with how the hospital system worked. During his admissions, he would comply with taking his medications in order that he could be released as soon as possible.

Norman Reid's mental and physical health were deteriorating badly; his propensity for violence was increasing; and his insight into his illness was virtually non existent.

Even Dr. Ladha commented that he "would have a sense of apprehension when Norman Reid was discharged." The apprehension related to Norman Reid relapsing and experiencing "an episode of acute psychosis ... behaviour amounting to harm for himself or other members of the Community ...."

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[10] Sandra Burke, Inquiry Brief, at 20-27.

There were several points highlighted by Glenda Webber in summarizing the social work files:

- Ethics prevents contact with other agencies without the patient's consent (exceptions noted)
- Much more could have been done for Norman Reid if he had wanted it. He wouldn't take advantage of services which were free to him. Norman Reid did not want local social worker involved.
- Upon admission, much time is spent on financial issues which is stressful to the patient.
- Norman Reid did not want to be told how to spend his money (i.e. Light and Power)
- I never felt threatened by Norman Reid

Similarly, from a psychiatric nursing perspective, we heard from Kim Parrell, B.N.. Half of her work time is dedicated to patients diagnosed with schizophrenia and she has dealt with hundreds of such patients. In her experience, Norman Reid was an exception given his aggression, lack of insight, extreme reluctance to treatment, and real resentment toward the involvement of anybody. Insisting on his rights, he wanted his status reviewed and always said that the R.C.M.P. had no right to "bring him in." On one occasion, in 1999, it took 12 men to subdue him in the hospital for an injection and then he was still struggling.

Dr. Michael G. Rayel was the only psychiatrist to examine Norman Reid outside St. John's. This session took place over the course of approximately one hour on September 8, 1999 at the Dr. G. B. Cross Memorial Hospital in Clarenville. The report generated is part of two exhibits JG#2 and DV#1 (admission 12). The entire forensic evaluation consists of six pages resulting from the "stick incident." Dr. Rayel concluded that "at the time of the incident, Mr. Reid is suffering from a mental illness with significant impairment of his ability to conform his behaviour to the requirements of the law and his capacity to appreciate the wrongfulness of his actions."

It is illuminating to carefully read this Forensic Evaluation and it is included in its entirety as Appendix "B". It is clear, from this report, that the "Chronic Schizophrenia" was in "acute exacerbation" and that there was a substantial risk in "further deterioration of his status. Furthermore he would continue to pose a threat to others."

During his 12th admission (September 9, 1999 to November 29, 1999) Norman Reid, through medications and confinement within the hospital, was made well enough to be released to a community and family who were astute enough to realize that his mental health was getting much worse.

Following yet another threat of violence to a female citizen of Little Catalina, Norman Reid was again certified and admitted to the Waterford Hospital for a 13th time where he stayed from June 28, 2000, until July 19, 2000. Again, he was made well enough to have his status changed to voluntary, and he self-discharged against medical advice.

A nurse noted that he was not consenting to have his family contacted and that he would make his own arrangements for medications and promised to keep appointments with Dr. Ladha.

Within 37 days Norman Reid threatened three R.C.M.P. officers with an axe and was shot dead.

e. Social Support

Norman Reid's adult life was miserable. Described in a more literary style ...

> "Norman Reid was tormented by acute, sometimes florid, mental illness. The illness was, then, irregularly if ever self-medicated to control his behavioural accesses, although medically prescribed. His was a solitary existence. He lived in spartan shelter unserviced by hydro or water; dieting, largely, on tinned staples and tobacco, funded from woefully inadequate state allowances. Frequently, he was shunned, feared, derisively-treated, and physically mistreated by some civilians, including some family members, in Little Catalina and elsewhere. He was poorly understood. He lacked affection.[11]

From the late 1970's to the early 1990's, there were periods of employment and employment insurance benefits. He had been receiving social assistance as early as 1979. In later years, Norman Reid's primary source of income was social assistance.

From 1979 to late 1991 when he moved into his uncle's house, there were many issues with Norman Reid and the Department of Social Services including:

1) issuance of drug cards while working or on E. I.

2) house visits

3) transportation

4)filling out forms

5) emergency assistance

Once into his uncle's home, Norman Reid found it very difficult to make ends meet. In 1993, the local MHA attempted to get more social assistance for Norman Reid, but he was already receiving the maximum basic benefit. An electric stove was approved in April

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[11] David C. Day, Q.C., Inquiry Brief, at 55.

1994. The following month there was a disconnect notice from Newfoundland Light and Power.

From then we see, over the last years of his life, a bureaucratic nightmare involving:

1) extra payments for such things as transportation, shoes, food, and light and power
2) budget plans
3) housing repair programmes
4) reconnect fees
5) civil action by Newfoundland and Light and Power
6) temporary long term assistance

Norman Reid lacked the capacity and will to sensibly budget the meager resources he had, squandering various amounts on cigarettes. He was undoubtedly living under an enormous amount of stress as a result of the poverty itself, let alone the pain of his mental illness. The stress of his deplorable living conditions was likely to have contributed to some of the psychotic episodes.

Perhaps the most frustrating aspect of the bureaucratic nightmare was the fact that Norman Reid's electricity was never hooked up even though the wiring had been satisfactorily completed. A request for $34.50 to pay the expense of the inspection was turned down because it was less than $50! Why the manager of Social Services denied the social worker's request or why the family did not pay the $34.50 still baffles me.

Regrettably, only seven or eight visits were made to his home by social workers. No case conference was ever held to discuss Norman Reid's plight. A social welfare assessment had not been completed because no one asked for it to be done.

By June of 1999, after considerable advocacy, a flat rate disability allowance of $125 was approved. This amount was approved again in 2000.

Everyone who saw the photos of Norman Reid's residence was astounded at the squalor, filth and absolute wretched living conditions. This was a most difficult situation for all involved including the social workers and the family.

Norman Reid could have lived in better accommodations that were clean and warm, but he refused to move. Norman Reid could have had a clean house but refused the help. Norman Reid could have had electricity but refused the budget plan. Norman Reid could have been nourished, but he refused meals and refused to stop smoking.

f. Contacts with R.C.M.P.

The only contact between the R.C.M.P. and Norman Reid, prior to 1986, was several transports to the Waterford Hospital for criminal behaviour or as the result of complaints. In November 1986, he was convicted under the *Food and Drugs Act* of possession of a restricted drug, and fined by the Court in the amount of $150.

From 1993 to his death in August of 2000, there were no fewer than 14 official complaints against Norman Reid. In addition, for the 13 months prior to his death, there was an average about one anonymous complaint per month.

There were powerful local dynamics involved in making a formal complaint and following through. The extreme degree of these dynamics we may only imagine and never fully understand. There were many people who were afraid of Norman Reid and reluctant to seek police help. Even the complaint by Norman Reid against others, namely two of his brothers, for alleged assaults were not pursued.

As a result of complaints made by the citizenry of Little Catalina to the R.C.M.P., there were five convictions, three acquittals, three findings of not criminally responsible by reason of mental disorder, one peace bond, and numerous matters not pursued.

Compelling details about R.C.M.P. concerns with Norman Reid are found in exhibit JD#5, an application under s. 111(1) of the Criminal Code (Firearm Prohibition Order) with a supporting 18 paragraph affidavit. This application from November of 1999, was not pursued by the Crown Attorney's Office.

A memo dated July 14, 2000, was forwarded to the Crown Attorney's office by Constable Curiston. Two brief excerpts follow:

> "I am forwarding this letter to you on behalf of some of the citizens of Little Catalina who are grievously concerned with the actions of Norman Edward Reid a member of their Community. On two different occasions I answered telephone calls from persons who have expressed extreme concern with respect to Mr. Reid's behaviour. As I spoke to each person respectively, one thing became apparent, the fear of retribution from Mr. Reid should a complaint with respect to the laying of charges against him be entertained by the police."

> "Each of these individuals expressed a general fear of the potential of Mr. Reid's behaviour. I was informed that based on his previous behaviour and that his steady personal decline forms the basis of their concern. I was also informed that the police are not even aware of the extent of Mr. Reid's behaviour because the police were never notified."

Following the Review Board Hearing of July 18, 2000, Constable Graham forwarded a timely detailed e-mail message about Norman Reid concerning conditions of release and the process generally.

> "Constable Graham also made extra efforts to deal with the situation. He too wanted to be heard at the MHRB Hearing. Once Norman Reid had been released by The Waterford and the MHRB, he drafted the memo(Exhibit JD No 1), which was a plan to deal with future problems and to alert all the members of the problem. This memo was criticized by some counsel as if it were somehow inappropriate. To the contrary, it was entirely appropriate under the circumstances since Constable Graham knew that sooner or later the R.C.M.P. would have to deal with Norman Reid because nobody else was going to."[12]

As Norman Reid's mental condition worsened, community fear grew. His resistance to the police escalated from resisting with some violence and no weapons to much violence with a rolling pin and hockey stick to a small axe on the date of his death.

Despite suggestions to the contrary, there is no evidence that any R.C.M.P. members ever threatened to shoot Norman Reid. There is no evidence, medical or otherwise, that any R.C.M.P. members ever significantly injured Norman Reid in their dozens of interactions. There is no evidence that any R.C.M.P. members conspired "to get" Norman Reid. They were, throughout all their dealings with Norman Reid, amazingly restrained despite what surely must have been severe frustration with a system which readily provided a revolving door.

Unfortunately, despite all their good intentions, the R.C.M.P. were not as successful as they clearly wanted to be in offering protection to others from Norman Reid. It also proved to be an elusive goal protecting Norman Reid from himself and those who taunted him mercilessly. Norman Reid was both an offender and a victim, all the while being seriously mentally ill.

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[12] Nicholas Avis, Q.C., Inquiry Brief, at 23.

g. Provincial Court Orders

Provincial Court, sitting in Bonavista and St. John's, had occasion to adjudicate cases involving Norman Reid. No decision of the trial judges was ever appealed, although some were criticized.

In August 1995, Judge Rorke, at St. John's convicted Norman Reid of two counts under S. 267(1)(a) C.C.C. and S.740(1) C.C.C. following guilty pleas. Norman Reid received a suspended sentence with probation for three years and victim fine surcharges.

One of the probation conditions was: "take all medications prescribed for you as prescribed." There was general, albeit reluctant, compliance with this condition. The Probation Order of Judge Rorke proved to be effective. During this three year period there were fewer and less serious encounters with the police and no admissions to the Waterford Hospital. However, after the probation order expired, Norman Reid spiraled downhill at an accelerated pace. The order for Norman Reid to take his medication was made under the authority of the Criminal Code, Section 732.1(3)(h) which reads as follows:

> "Comply with such other reasonable conditions as the court considers desirable for securing the good conduct of the accused and for preventing a repetition by him of the same offence or the commission of other offenses."

Counsel for the Canadian Mental Health Association has adamantly asserted that this was an unlawful Order. I disagree. There has been presented to me no case law from the Appeal Courts of Newfoundland and Labrador, nor the Supreme Court of Canada which would preclude that approach here in this particular fact situation.

In Manitoba, the Court of Appeal in *R. v. L.* (2001) 152 C.C.C. (3d) 572, ruled in the case of a seventeen year old young offender, that the condition to "take medication as prescribed by Dr. Varsamis" was not proper, primarily because it was contrary to Section 26 of the *Mental Health Act, S.M. 1998, c.36,* also there were some *Charter of Rights and Freedoms* concerns.

One of the leading cases in this area is *R. v. Rogers (1990)* 61 C.C.C. (3d) 481 in which the British Columbia Court of Appeal ruled as follows:

> "In my opinion, a Probation Order which compels an accused person to take psychiatric treatment or medication is an unreasonable restraint upon the liberty and security of the accused person. It is contrary to the fundamental principles of justice and **save in exceptional circumstances, cannot be saved by Section 1 of the Charter**. Exceptional circumstances are not present here."

Like Norman Reid, Donald Rogers had a "history of noncompliance with prescribed treatment and medication," and was "suffering from a chronic mental illness, schizophrenia." While Mr. Rogers had a lengthier criminal record than Mr. Reid, arguably, Mr. Reid was more violent and dangerous. Coincidentally they were born in the same year.

Between the sentencing date, May 22, 1990, and the time of the appeal (decision December 19, 1990), Mr. Rogers was regularly under the care of a doctor and was "taking medication as prescribed."

In striking down the original probation order, the British Columbia Court of Appeal imposed the following conditions, which apparently have been locally dubbed the "Rogers' Conditions."

> 1. You will take reasonable steps to maintain yourself in such condition that:
>
> (a) your chronic schizophrenia will not likely cause you to conduct yourself in a manner dangerous to yourself or anyone else; and
>
> (b) it is not likely you will commit further offences.
>
> 2. You will forthwith report to a Probation Officer at 275 E. Cordova St., Vancouver, B.C. and thereafter, if directed to do so, you will forthwith report to the Inter Ministerial project at 219 Main St., Vancouver, B.C.
>
> 3. You will thereafter attend as directed from time to time at the Inter Ministerial project for the purpose of receiving such medical counselling and treatment as may be recommended except that you shall not be required to submit to any treatment or medication to which you do not consent.
>
> 4. If you do not consent to the form of medical treatment or medication which is prescribed or recommended, you shall forthwith report to your Probation Officer and thereafter report daily to your Probation Officer. If directed to do so by your Probation Officer, you shall report to the Inter Ministerial Project at 219 Main Street, Vancouver, B.B. for the purpose of being monitored with respect to a possible breach of Condition 1 above.
>
> 5. You shall provide your treating physician with a copy of this order and the name, address and telephone number of your Probation Officer. You shall instruct your treating physician that if you fail to take medication as prescribed by him or fail to keep any appointments made with him, he is to advise your Probation Officer immediately of any such failures.
>
> 6. Except when eating in a restaurant you will not have any knife in your possession.[13]

The Appeal Court also increased Mr. Rogers' Probation Order from fifteen months to three years.

A check with the Court and other records shows that Donald Rogers was convicted of further offenses in 1992 and 1998. Between December 1990 and February 1992, his life had become more stable "since the British Columbia Court of Appeal's ruling placed an onus on him to take responsibility for managing his own mental health." In once instance he was described as "more pleasant than ever before."

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[13] *R. v. Rogers* (1990), 61 C.C.C. (3d) 481 at 489.

Mr. Rogers, who had moved to the downtown eastside of Vancouver, had been with the Inter Ministerial Project since 1987, which I understand to be an important, established community program. To have imposed "Rogers' conditions" on Norman Reid in 1995, without a similar program, would merely have set him up to be in breach of his Probation Order.

h. Regional Probation Officer

Gerard Greene has been the probation officer in Clarenville, responsible for the Bonavista Peninsula, since 1985. As an officer of the Court, his main duty is to supervise offenders who are ordered to report to a probation officer.

As a result of the August 1995 Court Order, Norman Reid's file came to the attention of Gerard Greene. Interestingly enough, Norman Reid had been placed on probation in September of 1994 but was not ordered by the local court to be under the supervision of a probation officer. While on unsupervised probation, Norman Reid committed three local crimes, for which he was sentenced in St. John's in August 1995.

The probation file is complete and well organized. It shows a very consistent and regular pattern of home visits (33) following the initial office appointment in August 1995 in Bonavista. There were substantial documented collateral contacts.

Norman Reid had his first visit with Gerard Greene on August 29, 1995. Norman Reid thought he should have a choice as to taking medication. Gerard Greene, in carrying out his duties as an officer of the Court, told Norman Reid that he was required to take his prescribed medication as ordered by the Court. Throughout the three year probation term, Norman Reid often questioned Gerard Greene as to why he had to take his medications and told his probation officer in no uncertain terms that when the order expired, he was no longer going to take the medication. Gerard Greene observed that Norman Reid did not know how sick he really was, appeared hyper and agitated about being on probation, and had a fear of going to jail.

Although Norman Reid had told Gerard Greene that he was regularly taunted and teased by the youth of Little Catalina and that he was by himself all the time, he did not want to move to better accommodations, did not want gifts nor clothing and did not want a homemaker to help - basically, he just wanted to be left alone. As well, Norman Reid never complained to the probation officer about how the R.C.M.P. treated him, but he did voice frustration about social assistance.

By October of 1995, Gerard Greene had completed a needs/risk assessment on Norman Reid who scored quite high at 22 (0-6 low, 7-14 medium, greater than 14 high).

While there was no case conferencing taking place, Gerard Greene did liaise regularly with Nurse Hancock and the R.C.M.P. and once with Bill Reid and Dr. Ladha.

As to the success of the probation period, it is fair to state that during that three year period Norman Reid was not hospitalized, he took his medication, visited his psychiatrist on an outpatient basis at the Waterford Hospital and, while he came to the attention of the police, he was not convicted of any offenses. During this time he was also respectful to Gerard Greene, always referring to him as "Mr. Greene," although he often appeared moody and somewhat argumentative about several issues.

Gerard Greene, who has had numerous professional contacts with mentally ill persons, agrees with court orders in these types of situations. He was realistic in understanding that he could only effectively work on the issues of taking medications, attending psychiatrist appointments and avoiding further court appearances. Throughout his dealings with Norman Reid, he was frustrated because of the poverty and squalid living conditions of Norman Reid.

i. Review Boards

i. *Criminal Code* Review Board

On April 20, 2000 the Provincial Court in Bonavista found Norman Reid not criminally responsible on account of mental disorder on three charges. As result of the Court's decision, the Review Board was to hold a hearing within forty-five days of the Court's finding.

Prior to the hearing and near the end of June, 2000, Norman Reid was certified under the *Mental Health Act* and on the 17th of July 2000, his status was changed by Dr. Niklas to voluntary on the basis that he was no longer certifiable. This was a consensual decision of the multi-disciplinary team.

The Review Board is established pursuant to Part XX.1 of the *Criminal Code of Canada* (s. 672.38(1)). Tom Mills, presently Director of Public Prosecutions, served as counsel for the Attorney General at Review Board hearings including the summer of 2000, when Norman Reid was before them.

Mr. Mills described for us the informal nature of the hearings and the inquisitorial role of the Board. Accused persons are normally represented by counsel from the Newfoundland and Labrador Legal Aid Commission. The Board usually relies on transcripts and reports and generally does not call evidence.

On the morning of July 18, 2000, there were five hearings, including that of Norman Reid. The Board did not hold a hearing within forty-five days of the Court's finding on April 20, 2000. Perhaps relying on "exceptional circumstances" they sought to deal with this matter within 90 days.

On July 18, 2000, Norman Reid was escorted to the Review Board hearing which, as per their custom, was held at the Waterford Hospital. He was escorted by his counsel, Bruce Short.

On July 18th, the Board only had three medical reports, the latest of which was from November 1999. There were two reports from Dr. Ladha and the report from Dr. Rayel.

It was the Attorney General's intention to have Norman Reid detained at the hospital as opposed to discharging him absolutely or releasing him on conditions, i.e. to build a case to show that he was a significant threat to the public. In fact, Mr. Mills was planning to call Constable Graham, who was there that day to testify. Little did they realize that Norman Reid's involuntary status had just been changed. When Dr. Niklas and his team found that Norman Reid no longer presented a danger to himself or others or to property, it would change things "dramatically."

Mr. Mills testified as follows:

> "Q. Okay. Can you explain that for us, right, with regard to the test under the *Mental Health Act*, vis a vis the test under the review board legislation?
>
> A. Okay. Perhaps I'll just try to recap the review board quickly. The review board criteria is a much more stringent criteria for having someone detained in the hospital or indeed even having conditions place upon them. The emphasis is upon the least possible interference with the liberty of the accused person. You have to remember that how that regime is set up is that this individual has not been convicted of a criminal offence, has been found not criminally responsible on account of mental disorder. They're not acquitted but there is this in between category.
>
> ...
>
> A. Okay. The crown has to prove that the offence occurred but then the judge, based upon medical testimony, finds him. We call it N.C.R., is the language that we use. Not criminally responsible. And the emphasis in those situations is to have the least possible restrictions upon the individual and that's quite clear from the regime set up in Part 10.1 and from the Supreme Court of Canada. So in relation to Mr. Reid's situation my review of the file indicated a number of things that would be very relevant to what conditions could be placed upon him or whether or not he could be detained.
>
> ...
>
> A. And at that point we basically discussed, well where can we go legally with the situation and now we know that he's not meeting the **Mental Health Act** criteria. So it was evident that there was no way he was going to meet the **Criminal Code** criteria and there was discussion that he would have to be released under the law."

After an informal meeting of the Chair, Crown, and Defence Counsel, the Board agreed to release Norman Reid on several conditions including that he take his medications. Incidentally, this particular condition was imposed with Norman Reid's consent. Norman Reid had been in the Waterford Hospital for about three weeks and it appears that he was willing to consent to anything to get out of there and return home.

There was apparently no consideration given to calling Dr. Niklas or any of the multi-disciplinary teams, nor to reviewing the current Waterford Hospital file.

Dr. Niklas did see Norman Reid later that day and asked him about the Board. Norman Reid knew his status was voluntary under the *Mental Health Act* but felt that he was discharged by the Board with no conditions. Norman Reid stayed at the Waterford Hospital until July 19th, when he self discharged against medical advice.

The order also contained a condition that Norman Reid attend for an appointment with Dr. Ladha or his designate. Dr. Ladha's secretary was unable to contact Norman Reid so the R.C.M.P. delivered a notice to Norman Reid on August 6th, just 19 days before his death.

ii. *Mental Health Act* Review Board

The *Mental Health Act*, R.S.N. 1990,s.15, provides for a Review Board to examine concerns about certification. None of Norman Reid's eleven involuntary admissions to the Waterford Hospital were brought to the attention of the Review Board.

Armed with an updated psychiatric report the Board hoped to finally review the matter in September. That, of course, did not occur. Norman Reid returned to Little Catalina, deteriorated rapidly, and following an armed standoff with the R.C.M.P., was tragically shot and killed within less than six weeks.

1.2 Events of August 26, 2000

a. Background, Complaint, Response and Stand-Off

Following his last release to the Community on July 19, 2000, Norman Reid was seen by several residents of Little Catalina, including family members. Generally, they felt that his mental condition was no better and possibly worse than before his last involuntary admission. He was seen behaving erratically within 24 hours of his last release. It is clear that Norman Reid did not take his medication, as prescribed, for his last 38 days. This was confirmed by the toxicology screen done at his autopsy which revealed that Norman Reid did not have a therapeutic dose of his medications in his blood on August 26, 2000.

At least 13 people saw Norman Reid on the day of his death and prior to the arrival of the R.C.M.P. Norman Reid's erratic behaviour included him waving his arms, shouting and swearing at no one, being hyper, raising his voice, praying, walking wildly, etc. Some residents of the community were afraid and nervous while others were not. Norman Reid had two heated arguments with his brother, Hilary Reid, about their father's shed. These confrontations added significantly to Norman Reid's already agitated state.

The officer who shot Norman Reid hosted a barbecue during the evening of August 25, 2000. Constable Graham socialized with his friends, went out to a local Club and had a few drinks. There was no evidence that he was intoxicated that night. He slept well and was fully capable of going to work the next day, August 26, 2000.

Weather-wise August 26, 2000, was a beautiful day. The food fishery was in full swing. Wind-speed varied from 35 km/h to 46 km/h from the southwest and the afternoon temperatures ranged from 15° C. to 23° C. At 4 pm, it was 21° C and the sun was shining.

Wade Eddy, then 22 and a resident of Little Catalina, had two contacts with Norman Reid that day. Norman Reid threatened to slit his throat and drink his blood and to do the same to children. The official complaint started at 3:17:38 pm. He told an operator at the R.C.M.P. Communications Centre:

> Norm Reid, swearing on, he's threaten, threaten cut youngsters throats, bawling out. That's what I heard anyway just swearing and everything on the youngsters. ... Now he never threaten me, just hear swearing and everything, pointing fingers at me, lets out oaths ... Cause if nothing don't be done soon something gonna happen. (Wade Eddy's call ended at 3:20:09 pm a total of 2 mins. 31 seconds.)

Roxanne Eddy, Wades's sister-in-law, agreed with his decision to call the R.C.M.P. She saw Wade as nervous and "white as a ghost." Her discussions, with him that day and two days later clarified that Wade Eddy had himself been threatened by Norman Reid and that Norman Reid had threatened his children in a very violent way. Within 41 seconds of the phone call, the operator contacted Constable Daley.

While the operator did not see the call as urgent, Constable Daley with his training, knowledge, and familiarity with Norman Reid felt that it was. Constable Daley then left Middle Amherst Cove and drove about four kilometers where he stopped the patrol car and contacted the Communications Centre by cell phone to confirm the original radio communication and to get further information. This confirmation call ended at 3:37:01, having lasted 1 minute and 11 seconds.

Constable Daley concluded that "... one should proceed with all due caution but with all due haste in order to secure a potential situation in Little Catalina ... would merit our fullest attention." At this point Constable Daley's knowledge of the situation consisted of many relevant facts including the following:

1. potential violent nature of Norman Reid;
2. Norman Reid suffered from schizophrenia;
3. Norman Reid was released on conditions by the Review Board;
4. Norman Reid was to be arrested if he breached or was about to breach the conditions;
5. Norman Reid's court appearances in April 2000 and the increased police presence;
6. Norman Reid's June 18, 2000, apprehension and the complaints leading thereto;
7. concerns and fears of many residents of Little Catalina re: Norman Reid; and
8. Norman Reid was a very unpredictable person.

Constable Daley then made a cellular call to Constable Graham, the senior constable who also had greater experience in dealing with Norman Reid. Constable Daley appropriately briefed Constable Graham and then contacted Constable Malinay. It was decided that Constable Daley would proceed to the general area and await the arrival of Constables Malinay and Graham at a vacant parking lot.

In his December 4, 2000, statement to the Ontario Provincial Police, Constable Daley indicated that he called Constable Graham and said, "Hey, we got it." This was interpreted by some counsel as an exuberance on the part of the police in that they finally had an opportunity to arrest Norman Reid and take him away with the hope that maybe, just maybe, something would finally be done. Constable Daley explained that this type of call would "give one no pleasure whatsoever"; however, it's not unentirely unexpected." It was seen as "a requirement to investigate an allegation."

The patrol cars proceeded to Forest Road, Little Catalina, arriving at approximately 3:52 pm within 34 minutes of the initial complaint. "Constable Graham indicated to our Operational Communication Centre that he wished the repeater system to be left up." Unfortunately the monitoring desired failed to take effect due to a less than perfect system.

A brief, helpful outline of the way in which matters unfolded has been provided in the written submission of Reid family Counsel, Thomas Williams.

> "As the officers approached a fence to the south side of the residence, Mr. Reid exited from a side door and stood on a small side landing, with a railing, which is commonly referred to as a "bridge." There was a brief verbal exchange between the officers and Norman, after which Norm re-entered the house through the side door and returned holding a small hatchet in his hand. While there has been a variety of evidence from civilian witnesses, the weight of the evidence is that the three officers did not draw their service revolvers until Mr. Reid appeared with the hatchet.
>
> It was at this point that the three officers took up strategic positioning with service revolvers drawn, to the north of where Mr. Reid was located. The officers were located approximately 20 feet from Mr. Reid in a parallel line to a fence, which separated the officers from Norman. There was approximately 15 feet between the officers, with Constable Daley standing between the Reid residence and the police cruisers, Constable Graham standing to his left, positioned directly in front of the bridge, and Constable Malinay standing to Constable Graham's left.
>
> During the intervening minutes following the commencement of the standoff, Mr. Reid remained on his bridge with the hatchet in his hand while the officers contained the scene by holding their positions and maintaining their weapons drawn and focused toward Mr. Reid at various intervals. While the evidence is not totally consistent in relation to these matters, it appears that a dialogue was achieved as between Constable Daley and Mr. Reid, with varying heightened levels of excitement and shouting occurring separately in between. It should be noted that Constable Graham advised Mr. Reid to

> "*put the axe down*" and that he was "*accused of uttering threats and assault with a weapon.*" Mr. Reid questioned why the police were there, who called them and ordered the officers to get off his property.
>
> It was around this point in time that Constable Graham attempted to pepper (OC) spray Mr. Reid; it struck Norman in the forehead and eye area, but had no effect. Shortly thereafter, Constable Graham motioned to Constable Malinay to trade places with him, and then positioned himself closer to Mr. Reid by moving in by the fence. It was then that Constable Graham attempted to extend his collapsible baton, his intent being to disarm Mr. Reid while his attention was focused on the other officers. He was not successful in having his baton go into a locked position.
>
> This standoff lasted for approximately 12-13 minutes when events began to spiral out of control. At this point, Mr. Reid made some movement to his immediate right, toward or onto the steps leading to his rear yard."[14]

The three officers contained the scene, consistent with their training, about 8 meters from Norman Reid. As to why they didn't move back further or withdraw generally, I am satisfied with the explanation of Constable Daley:

> "We had to stay there in order to prevent Mr. Reid from fleeing the location with the axe in his agitated state. I felt it incumbent upon myself, as I believe it would have been ... in the minds of my other two comrades, that there was no possible way that we could withdraw and allow the potential of Mr. Reid escaping from that area and possible doing harm to other people."

All three responding officers were questioned extensively about this distance of 8 meters and whether they might have moved back several meters to "allow more space and increased reaction time." It was their firm opinion that this distance was appropriate.

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[14] Thomas E. Williams, Inquiry Brief, at 23-25.

While standing back another 4 meters would have increased their reaction time by 50 percent as suggested by Mr. Williams, the responding officers felt unwaveringly that their duty was to protect the public and not allow Norman Reid the opportunity to suddenly exit his "bridge" to his left, run across the field and kill or seriously injure one or more of several bystanders in the area. The tragedy would undoubtedly be considered much worse if Norman Reid, in the presence of three members of the R.C.M.P., had attacked and killed an innocent citizen.

This approach to containment was affirmed by Sergeant Darryl Knox an expert in use of force and appropriate police responses.

Norman Reid may have felt more comfortable and less threatened if the Constables Malinay, Daley and Graham were further away. However, his comfort level was not the primary consideration for them. It was Norman Reid who escalated the situation by coming out of his house with the small axe.

While we may speculate as to whether or not he would have left his "bridge" and attacked somebody else if the police were significantly further away, this was a risk which these three members of the R.C.M.P. were not willing to take. Their containment decision affirmed by Sergeant Knox is acceptable to the Inquiry.

Constable Daley informed Norman Reid in clear and simple language that he was under arrest for threats and assault. He steadfastly refused to give up the axe.

Furthermore, the decisions of Constables Malinay and Graham to switch positions and for Constable Graham as the senior constable to position himself by the last standing post, i.e. within 3.9 meters of the bottom of the steps are not subject to criticism.

Throughout the standoff the officers kept telling Norman Reid to put down the axe even to the point of promising to put away their guns if Norman Reid complied. He did not comply and for most of the time made warning gestures with the axe in chopping motions sometimes above his head other times at chest or stomach levels. Sometimes he tapped on the railing of the bridge.

The officers assured Norman Reid that they would not hurt him. They pleaded with him to put down the axe. Norman Reid was very concerned about who initiated the complaint. Furthermore, he was adamant that the police couldn't make him do anything and enter upon his land. He refused on at least ten occasions to put down the axe.

Both Constable Graham and Constable Daley had contact via portable police radio with an operator at R.C.M.P. - O.C.C., the subject being extra backup. As a result, two members of the Clarenville Detachment, about 100 kilometres away, were already on their way. An attempt was also made to contact an off duty officer from Bonavista.

There were times when the voices of Norman Reid and the particular officer who was speaking were raised; also there were periods when voices subsided. One particular example was toward the end of the confrontation when Constable Daley asked Norman Reid in a conversational tone how he was feeling. This was a short-lived calming period during which Norman Reid inquired as to why the police were there. Constable Daley actually felt he was making some progress but, when the subjects of medication and the accusation of threats came up, Norman Reid became angry and demanded to be arrested.

Use of an R.C.M.P. negotiator was not feasible as the nearest one would have been in Holyrood. To not avail of family members or other civilians to diffuse this intense situation was a sound decision, primarily because of the edged weapon and the extremely agitated state of Norman Reid. The challenges presented here were far different from the "stick incident" the previous year.

At 4 pm, Constable Daley was informed that "Clarenville is on the way." Five minutes later the operator let them know that another constable from Bonavista was en route.

Prior to the brief calming period, Constable Graham tried to temporarily incapacitate Norman Reid with Oleoresin Capsicum - "O.C. spray," commonly referred to as pepper spray. This tactic was unsuccessful for a number of reasons including the wind, the distance, and that some people are not affected.

> "Constable Graham managed to get close enough to Reid to hit him with pepper spray. This has no debilitating effect whatsoever on Reid and may have served to elevate his excitement and agitate him further."[15]

Norman Reid was well aware of this as he wiped his head with his left hand and asked of Constable "What did you spray me with that shit for?".

During the "calming period," the senior Constable Graham, saw an opportunity to disarm Norman Reid with his Asp baton by moving over the fence where there was a gap and striking Norman Reid while his attention was focused on Constable Daley. The baton did not lock into its extended position and

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[15] Mark Pike, Q.C., Inquiry Brief, Vol.1, Part II, at 5.

> "Constable Graham, putting himself at risk, made a second attempt to disarm Reid using his Asp baton. Before the attempt is completed, Reid turned, ran down the stairs with the axe over his head attacked and threatened to kill Graham."[16]

These efforts of Constable Graham were clearly well-intentioned. He hoped to temporarily disable and disarm Norman Reid and bring this very dangerous incident to a close. I agree with Superintendent Michael Shard that these actions did not constitute misconduct, despite their being inconsistent with the use of force model.

b. The Actual Shooting and Events Following

Without warning, Norman Reid looked at Constable Graham, said "I'm going to kill you," very quickly descended the steps with the axe in his right hand at least at shoulder level and ran toward Constable Graham who yelled out "Stop, stop, stop!". Norman Reid did not. Constable Graham shot him five times. Norman Reid fell to the ground and died within a couple of minutes.

Two major issues in which this Inquiry spent a considerable amount of time was the manner in which Norman Reid was holding the axe and the location of Norman Reid when the first shot was fired.

It was of utmost importance that the Inquiry heard from all available eyewitnesses. The importance pertains more to the concept of a fair and full presentation of the evidence and the overall appearance of justice than it does to the accurate unfolding of the key events.

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[16] *Ibid.*

The shooting of Norman Reid was arguably the most sensational public tragedy in the history of the small community of Little Catalina. Everyone knew one another; many had seen the events while all had heard about them. Feelings were running high and there were many real factors which would adversely affect the ability of a local witness to give an accurate account of what actually occurred. By far, most tried honestly to recount what transpired. Only a few were stubbornly prevaricating on a few points in an attempt to persuade the Inquiry and the public in general as to their biased point of view.

The analysis of the physical evidence by Mr. Avis was helpful. This pertained to the following:

1. "Two bullets went through Norman Reid.
2. No bullet holes were found anywhere on the bridge, the steps, etc.
3. There were no drops of blood, bloodstains or blood patterns found anywhere on or near the bridge, the steps the doors or the concrete platform.
4. One bullet hole was found in the back corner of the house closest to the shed.
5. The location of the shell casings in the grass and the manner in which shell casings are ejected from a gun.
6. The blood in the grass closest to the upper most pylon.
7. The bullet pattern in Norman Reid's body.[17]

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[17] Nicholas Avis, Q. C., Inquiry Brief, at 34-37.

An examination of photos 220-229 of Exhibit DM#5, coupled with reliable eye witness testimony, causes me to conclude that there was no possibility whatsoever of Norman Reid being shot while on his bridge or steps. The conclusion of the Inquiry is that the first shot was fired at Norman Reid when he had one foot on the concrete pad and the other on the grass. At this time Norman Reid was within 3.4 m of Constable Graham.

Another key issue during the Inquiry was the five shots fired by Constable Graham. Police are trained to shoot at the centre of mass until the threat is stopped. Constable Graham fired one shot. After a brief pause he fired four more shots. From the first to the last shot, approximately two seconds elapsed. After the first shot there was still some forward movement but with subsequent shots, the body rotated and Norman Reid fell to the ground.

It may appear to some that five shots were excessive especially considering that, with the rotation, bullets four and five entered the body from the back area. However, it must be remembered that all shots were fired when Norman Reid was in motion and still on his feet. No shots were fired when he was down.

Experts such as Dr. James G. Young, Chief Coroner for Ontario, explained that most people shot by the police have multiple shots because one bullet quite often does not stop the threat. He also explained that it is not unusual for some shots to be in the back or rear area of a person.

The Inquiry concludes that the five shots in this case were not excessive and were consistent with established police training and reality.

Following the shooting, even as shock was setting in, lead Constable Graham ensured that various tasks were completed including getting Constable Malinay to go to Norman Reid, requesting Constable Daley to get latex gloves and a first aid kit, arranging for an ambulance, placement of orange cones as markers at the foot and head of Norman Reid's body, notifying senior R.C.M.P. personnel, securing the scene, etc.

Given the traumatic state of the three incident officers, particularly Constable Graham, the Inquiry is of the view that none of their actions subsequently warrant any criticism. Allowing family members and a nurse onto the scene was understandable. Hillary Reid, a big man in an angry state, insisted on going in. Constable Daley's decision not to prevent that was wise. Colleen Kennedy, an L.P.N. was only on the scene to offer assistance.

The decision to allow the body to be removed before the scene was processed was a difficult one. There was hostility in the air. Harsh words had been directed by family members and possibly others, to at least two of the police officers. Constable Graham sensed that "scene containment was gonna be a problem" and further that "Mr. Reid's body would be the focus of a lot of attention and crowd drawing."

Removal of the axe by Constable Malinay was determined by Superintendent Shard of the O.P.P. to not constitute misconduct.

Dr. James Young, Chief Coroner for Ontario, stated that this decision was understandable. He felt though it would have been better to have tried to work with the people and leave things as they were until the medical examiner arrived. In the end, he was very sympathetic to their situation and the removal of the body and failure to properly preserve the scene was of no significance.

Dr. Simon Avis, Chief Medical Examiner for Newfoundland and Labrador, indicated that it was acceptable to have removed the body as was done; he would, however, have preferred to have photographs taken beforehand. Similarly, Superintendent Shard was of the opinion that removal of the body did not constitute misconduct.

However, the failure to properly notify the Chief Medical Examiner or his designate until the next day cannot be justified. Dr. Avis did not expect the incident officers to "holster their guns and phone me right away." However, with the arrival of several R.C.M.P. members later that evening, Dr. Avis or Dr. Denic, who was on call, should have been officially contacted. They were contacted about another sudden death that day from the same district. Corporal Gerard O'Brien of the Serious Crimes Unit admitted that this was an oversight. The Corporal from Clarenville who would have been responsible for this official contact apologized for her error.

Of greater concern to the Inquiry, is the question of who should have been in charge of this investigation. I agree with the position taken by Dr. Avis that from the start, this was not a criminal matter. Accordingly, the police should have been assisting him. Similarly, in Ontario, this case would have been under the control of the Coroner's office. Direction and authority would have come from the Chief Medical Examiner and issues such as the general warrant and media releases would not have arisen as they did.

If during the course of the investigation by the Chief Medical Examiner, evidence surfaced of a crime being committed, then it would switch to a criminal investigation.

Potential *Charter of Rights* issues should be covered by strict adherence to the provincial law, competent leadership, and orderly transfer of existing investigation files. In any event, whether criminal or otherwise, the Chief Medical Examiner and the police would be working closely together.

Of far lesser concern to the Inquiry is the fence and the question of how and why part of it came down after the shooting. The evidence is confusing and contradictory.

Grant Sheppard, Ambulance Attendant, admitted to walking "on a portion of the fence board to get out. It was one paling on the bottom.". The incident officers did not admit to knocking down the fence.

A careful examination of photos 322 to 334 of DM#5 (reconstructed fence) shows that the section between Constable Graham and Norman Reid was neither a barrier to shooting a pistol, throwing an axe, striking Constable Graham with the axe, nor Constable Graham or Norman Reid proceeding over or through the fence with ease.

As to how sections one, two, and three (left to right) in photo 151 of DM #5, ended up down, the evidence is inconclusive.

> "... it is entirely plausible having regard to its condition that the fence just fell once the support of section one had been removed. Similarly, Constable Graham and Constable Malinay both rushed in to Norman Reid's body and would have been in a very heightened state. It is possible that on their way in part of the - just - section of the fence was disturbed without them knowing it. It would have taken very little to loosen the top board ...".[18]

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[18] Nicholas Avis, Q. C., Inquiry Brief, at 77.

Although we cannot be certain, it is quite possible that one or two police officers caused part of the fence to come down. However, what we can be certain about is that it was not done with improper motives.

1.3 Autopsy

The autopsy was conducted in St. John's, by Dr. Nebojsa Denic, F.R.C.P.C. on August 27, 2000. The first and second pages list the following:

FINDINGS

1. Multiple gunshot wounds (five) of the torso and extremities.
    a) Range: distant (no evidence of close range discharge of a firearm on the skin)
2. Blunt force injury: recent bruise of left inguinal region.

CAUSE OF DEATH

Exsanguination due to multiple gunshot wounds of the torso and extremities.

MANNER OF DEATH

Homicide

TOXICOLOGY

Blood ethanol negative.

Drug screen negative.

The fact that the drug screen was negative clearly reveals that there were no therapeutic levels of his medication in Norman Reid at time of death.

Dr. Denic testified in detail about the five bullet wounds. It is a rare occurrence where the subject is stopped on the first shot. Dr. Denic who had considerable experience in Yugoslavia prior to his arrival in Canada in 1992, told us of a man who was able to walk approximately one hundred metres despite having been shot through the heart.

The five wounds were consistent with Norman Reid being in motion, rotation commencing on the second wound, falling down commencing on the fourth wound. At the time of the last shot Norman Reid was not on the ground, but his right knee was almost "totally bent." While wounds four and five clearly entered his body from the rear, one must remember that the shots took place over a period of about two and a half seconds and that Norman Reid was in motion.

> "The fact that his body rotated during the shots and he fell backwards suggest that the location of his feet is the minimum distance he was from Constable Graham and that he was probably closer".[19]

Indeed, after Norman Reid left the bridge and steps "the location of his feet marked by the westernmost pylon (ie. nearest Forest Road), marked his maximum distance from Constable Graham".[20]

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[19] Nicholas Avis, Q. C., Inquiry Brief, at 79.

[20] David C. Day, Q. C., Inquiry Brief, at 225.

2. R.C.M.P. Investigation

The R.C.M.P. investigation commenced immediately from the time of the shooting. Constable Daley requested the Communications Centre to call for an ambulance, which was done. Some perimeter security followed with Constable Daley stringing up bright yellow tape. For the most part there was no contamination of the scene.

Within an hour, three R.C.M.P. members were at the scene, Constable Hansen from Bonavista and Constables O'Keefe and Beaumaster from Clarenville. Constable Graham had left in the ambulance with Constable Malinay following in a patrol car. Before midnight, despite distance and a summer weekend, a full team of investigators, specialists and an R.C.M.P. dog were on site. Major Case Management was in place.

A professional thorough investigation was conducted between August 26, 2000 and September 11, 2000, with an initial report to the Department of Justice in that same month of September.

The R.C.M.P. investigation was scrutinized closely by the O.P.P and in a letter dated December 7, 2000, 12 concerns were raised. The R.C.M.P. reply dated January 18, 2001, responded to these points. The Inquiry heard substantial evidence in most of these areas. Most of the concerns "were explained in an appropriate manner."

Nevertheless, there were some mistakes, including inaccuracy in the initial press release and failure to promptly notify the Chief Medical Examiner of the death.

The early removal of the hatchet from the scene prior to the warrant coming into effect but after it was issued, has been explained by the R.C.M.P. as having arisen out of a concern to preserve evidence - fingerprints and possible powder residue. However, these purposes could have been realized by other means according to Detective Inspector Gentle of the O.P.P., who would have preferred that the axe be left there with a suitable covering over it.

The canvassing of witnesses was undertaken by Constable Beaumaster on August 26th with important information being passed on to investigators who interviewed witnesses starting the next day. The explanation given by Sergeant Slaney on the subject of number of witnesses is accepted. There were only one or two eye witnesses who were not interviewed. Given the large number who were interviewed, the vantage points of those who weren't, and the time constraints the R.C.M.P. were working under, this concern warrants no criticism.

During the R.C.M.P. investigation there was concern expressed by Eunice Reid Butler about the manner in which her teenaged son, Daniel Reid, was interviewed by Corporal Dwyer and Constable Russell at a vacant parking lot just outside Little Catalina.

Corporal Dwyer told Daniel that he didn't appreciate his attitude. Daniel later claimed that Corporal Dwyer was loud and intimidating and that as a result he was frightened. Eunice Reid Butler described how Daniel was shaking when he saw her and that he was put on medications. Her observation was that the O.P.P. showed more respect than the R.C.M.P.

The Inquiry does not take issue with the investigative techniques of Corporal Dwyer and Constable Russell. There was nothing improper about affording young Daniel a degree of privacy on the outskirts of the village. While Corporal Dwyer did seriously challenge Daniel on his attitude, he did not "bawl out at him".

Eunice Reid Butler did not wish to make a formal complaint but she did express her concern to Corporal Baker and also Inspector McLoughlin. Corporal Baker and Sergeant Slaney attended at her residence on September 1, 2000, and offered a somewhat conditional apology which was accepted by Eunice Reid Butler.

The issue of obtaining a search warrant for the purpose of obtaining evidence of a crime, committed by the deceased, was unusual and perhaps unprecedented. In 29 years on the bench, I have never heard of such a warrant, nor have experienced Inquiry Counsel, nor any of the witnesses including Tom Mills, Director of Public Prosecutions. Mr. Mills further went on to state in his testimony (Volume XXXIX, p. 94):

> "So you were not investigating the homicide of Mr. Reid, but you were investigating Mr. Reid's actions alone. So, in relation to impartiality, yes, I had a concern that there was not an appearance of impartiality."

The O.P.P., in reviewing the issue of obtaining the warrant, concluded that the information was presented in good faith, accurately to the Judge and that there was no misconduct on the Information to Obtain a Warrant.

I agree with that opinion; however, the better course would have been to rely on the common law authority because it was essential to preserve the scene.

The best course would have been to treat this investigation as one under the *Fatalities Investigations Act,* S.N.L. 1995, c. F - 6.1, in particular ss. 5, 9, 11, and 12. I agree with the Ontario position, supported by Dr. Simon Avis, that a case like this must start under the provincial law with the investigation directed by the Chief Medical Examiner. If necessary, this investigation could switch to a criminal investigation.

In the hypothetical case of an incident officer subsequently being charged, there would be no *Charter of Rights and Freedoms* problems with seizure of the deceased's property, nor the officer's gun, nor any of the officer's paraphernalia at the scene. The only potential *Charter of Rights and Freedoms* issue might arise with regard to a statement by that incident officer, but it would likely not be of any serious concern because the common law and provincial law were being carefully followed and most importantly the officer was not a suspect, ie. the officer was not in any manner, under suspicion. If he did become a suspect and was subsequently detained or arrested, then, of course, *Charter of Rights and Freedoms* rights would have to be properly afforded.

In this case, Constable Graham was never a suspect, while some people with heavy bias may have felt otherwise. Constable Graham was never detained nor arrested by either the R.C.M.P. or the O.P.P. A warrantless search of Norman Reid's residence, carried out in good faith, could not in any way cause a potential for the fruits of that search to be inadmissible.

The question remains as to who determines if the investigation starts out as criminal or provincial and who determines if it changes in midstream. In reality, the police and the Chief Medical Examiner work hand in hand, and undoubtedly would confer in earnest. If the problem hasn't arisen in Canada's largest province and if the authorities in Ontario do not see this as an issue, I believe that the R.C.M.P. concerns are unfounded.

While the R.C.M.P. investigation had some imperfections, it was thorough and professional. There is no hint of any misconduct nor incompetence.

3. Ontario Provincial Police Investigation

On August 26, 2000, Assistant Commissioner Lawrence G. Warren of the R.C.M.P. was attending meetings of the Canadian Association of Chiefs of Police in Saint John, New Brunswick. Superintendent Lynch advised him of the death of Norman Reid and briefed him then and daily thereafter on developments.

Learning of continuing concerns in the media "about the R.C.M.P. investigating the R.C.M.P.," Assistant Commissioner Warren contacted Deputy Commissioner Terry Ryan, his supervisor in charge of the Atlantic Region, and advised him that he was going to request that the O.P.P. to conduct an independent parallel criminal investigation.

This unprecedented step for Newfoundland and Labrador was not ordered or forced by the Minister of Justice who had authority to do so; rather this was at the invitation of the R.C.M.P.

All the while, concerned about the morale of all R.C.M.P. members and personnel in this province, Assistant Commissioner Warren sent out a message to his people that the request for the services of the O.P.P. "is not a sign of loss of faith in our organizational abilities or our members' abilities to be impartial but rather a public declaration that our investigations are, in fact, impartial and open to public scrutiny.".

There was a phone call and correspondence with O.P.P. Commissioner Gwen Boniface. Meetings in St. John's commenced September 5, 2000. Detective Inspector Ronald Gentle, head of the O.P.P. investigative team, returned to Ontario on September 6, 2000, and prepared a team of four investigators and two forensics personnel. Detective

Inspector Gentle arrived in Newfoundland and Labrador with his team on September 12th and were duly sworn in as supernumerary constables under the *R.C.M.P. Act*.

Meetings were expeditiously held with Dr. Avis, the R.C.M.P. and Thomas Williams on behalf of the Reid family. By the 16th of September, the team was settled in the area and interviews commenced.

Notwithstanding the R.C.M.P. request for the O.P.P. to conduct a criminal investigation, Detective Inspector Gentle stated that they were investigating under the *Fatalities Investigations Act*.

> "In order to conduct an investigation to determine whether a criminal act has taken place, you have to start somewhere, and you start in Ontario under the *Coroner's Act*. Here, I believe, it would be the *Fatalities Investigations Act*."

Also, despite the parallel investigation, Detective Inspector Gentle was of the opinion that the O.P.P. investigation started on September 11, 2000, and that the R.C.M.P. investigation was terminated at that time.

Assistant Commissioner Warren promised complete cooperation and total access to the exhibits and documents. No parameters were set on the O.P.P. team. Detective Inspector Gentle told the Inquiry that he and his team were shown excellent co-operation by the R.C.M.P.

After a comprehensive, impartial and professional investigation, the O.P.P. concluded that there were no reasonable and probable grounds that any of the incident officers had committed any offence and that no charges should be laid. This was the same opinion as put forth by then Assistant Director of Provincial Prosecutions Harold Porter.

Furthermore, there was nothing in the R.C.M.P. response to warrant any misconduct charges.

While there were some noted deficiencies in the R.C.M.P. investigation, none were of a serious nature and in the end made no real difference to the outcome.

While there may be residual pockets of discomfort in the minds of some members of the public, I am satisfied that any concerns about the impartiality of one police force (O.P.P.) investigating another police force (R.C.M.P.) are unfounded.

Issues of Legislation

4.1 *Mental Health Act*

During that very period in 2000, when two mentally ill men in Newfoundland and Labrador were shot and killed by police, an important book was in the process of being published. That book, which has provided considerable insight, is entitled, Canadian Mental Health Law and Policy. Its authors are John E. Gray, Margaret A. Shone and Peter F. Liddle. The publisher is Butterworths Canada Limited 2000.

In the introductory chapter, the authors write of the importance of mental health laws at page three.

> "Mental health laws are especially important to individuals in the group of about 800,000 in Canada with a lifetime risk of experiencing a type of mental illness which frequently diminishes insight (manic depression at 1.4 per cent and schizophrenia at 1.0 per cent). Without compulsory admission and psychiatric treatment, people who cannot accept voluntary treatment are abandoned to the consequences of their untreated illness. Untreated these illnesses have a high fatality rate (10-17 per cent) and higher lifetime disability rates than many physical illnesses. These illnesses can cause great personal suffering including despair to the point that people, for no reason apparent to others, kill themselves to escape the torment of feelings of worthlessness or because a voice (hallucination) commands them to. People with paranoid schizophrenia with delusions of being poisoned or persecuted often cannot work because they are fixated on escaping their persecutors and occasionally lash out at them. Frightening hallucinations, manic excitement, intense anxiety, distorted judgment and illogical thoughts are some of the other symptoms that no only lead to suffering of the individual but also interfere with one's ability to work and fulfil his or her role in families and in society.
>
> Mental illness and mental health laws affect more than the individual with the illness. They affect those who care about the person's health and happiness, such as family and friends who struggle to persuade the person to get treatment the person believe is unneeded. Untreated mental illness also affects others in harmful ways."

Issues of policy and reform are addressed throughout the text and are succinctly started at page five.

> "While compulsory treatment will usually restore people's freedom of thought from a mind-controlling illness and restore their liberty by releasing them from detention, their feelings of autonomy and legal and civil rights may be impacted. For this reason, it is necessary for legislation to balance all their needs and those of society as a whole. The major changes in mental health laws over the decades and the current debates revolve around three great societal values: the need to provide protection and assistance to those who, through no fault of their own, cannot assist themselves; the need to protect other members of society from the conduct of those whose brain illness puts them out of control of themselves; and the need for individuals to be as unfettered by legal intrusions as is possible in a civilized democratic society."

A succinct overview and background of the *Mental Health Act*, S.N. 1971, and failed efforts of reform are found in the submission to Norman Reid and Darryl Power Judicial Inquiries by the Department of Health and Community Services in October 2002.

> "Mental health legislation provides a framework upon which decisions can lawfully be made on behalf of those who, because of severe mental illness, are unable to make decisions about their mental health care. In this province, the *Mental Health Act* 1971 is in effect and has remained virtually unchanged up to today. It is the only legislative authority, apart from the *Criminal Code of Canada* (C.C.C.) Which permits detaining and treating individuals against their will. It is obvious that any restriction on liberty and other individual rights must only be imposed with compelling and valid rationale and need, and that adequate safeguards must be in place to protect the right of individuals who come under the jurisdiction of the Act.
>
> Background
>
> The *Mental Health Act*, although an essential component of the mental health service delivery system, is designed to apply to only a small number of individuals who suffer from mental illness or mental health problems. The majority of people who require mental health services receive them on a voluntary basis, just as any other health service would be provided. The *Mental Health Act* was developed to assist a small number of individuals who, because of a mental illness, require temporary containment and

treatment in a designated treatment facility. It provides mechanisms for the involuntary admission and treatment of a person where the safety of the person or the safety of others is in jeopardy and the person refuses support and intervention voluntarily. This process is known as certification or involuntary admission and must be authorized by two medical practitioners. The data that are available about the individuals and situations that result in assessment and treatment under the *Mental Health Act* are grossly inadequate. No provincial database exists and individual regional health boards maintain their own patient records. There is no requirement for any provincial reporting by the health boards and, therefore, the data are rarely examined as a whole.

As early as 1978, the Federal Department of Health, like its provincial counterparts identified concerns with the existing mental health legislation. There was a lack of provision for competency, consent for treatment and patient rights as well as the need to modify sections of the Act to make it more consistent with current practices and services. These gaps still exist today. Impetus to review the Act was also provided through the recommendations made in the report of the Provincial Court Inquiry by Judge E. Langdon into the cause of and circumstances surrounding the death of Thomas Hagan, Kingman's Cove, Newfoundland and Labrador, which was submitted to the Honourable Minister of Justice in May 1980.

In response to these developments, a Ministerial Advisory Committee was established in July 1980 by the Minister of Health, chaired by dr. C. Pottle, with representatives of the Department of Justice, Office of Legislative Council, Canadian Mental Health Association, The Newfoundland Psychiatric Association, Newfoundland Hospital Association, Waterford Hospital, Memorial University of Newfoundland and Labrador, Department of Health and other expert resources. A report was prepared and submitted to the Minister of Health, "Report of the Minister's Advisory Committee on the Mental Health Act, June 1983", (Appendix "C"). The report contained recommendations in two areas: 1) changes in the legislation; and 2) changes in the policy that affects the delivery of mental health system. Although it was acknowledged that the primary mandate of the committee was on legislative reform, the committee found it impossible to be silent on the changes necessary in the hospital and the community system if services to persons with mental illness were to become effective. In essence, the Report recommended that a new *Mental Health Act* be drafted based on the principles and policies outlined. The report covered

1. Admission of Patients to Psychiatric Facilities
2. Discharge including Extended Leave and Probationary Discharge
3. Mental Competence to Consent to Treatment and to Manage Estates

4. Review Boards
5. Justice Patients
6. Legislation and the Service System.

> A significant development during the life of the Ministerial Advisory Committee was the introduction of the Canada *Charter of Rights and Freedoms* in 1982 to which all laws in Canada must conform. Indeed, one of the main stumbling blocks to the introduction of some of the suggested directions in the report was concern that an act which included arbitrary detention and treatment might not survive a challenge under the Charter. The *Mental Health Act* in this province has never been tested as to its conformity to the *Charter*.
>
> The Report was accepted by Cabinet and direction was given to draft a new Act for introduction into the House of Assembly. A draft Act was completed by the Office of Legislative Council in 1983. Since then, there have been a number of attempts to bring forward a new *Mental Health Act*, however there has been limited ability to reach consensuses among all the sectors as to what should be the philosophical basis for mental health legislation reform.
>
> The most recent initiative, started in October 1999, involved service providers, consumers and their families, community and advocacy groups, as well as departmental staff. The stakeholder group has met and reviewed the existing Act as well as the draft legislation that was prepared in the mid 1980s. The *Mental Health Act* is a difficult and controversial piece of legislation that must strike an acceptable balance between the rights of and individual and the protection of public from unnecessary harm or risk."[21]

That we in our province have the oldest and most outdated *Mental Health Act* in the country goes beyond embarrassment - it is a grave concern.

Numerous reasons, all unacceptable in my view, have been offered as to why new legislation was never brought forward in our province. Government, for the last twenty years, simply did not have the will to make it happen especially in light of financial constraints and lack of consensus. This continuing absence of consensus compels a most urgent basis for leadership.

The opinion of witnesses including Debbie Sue Martin, Director of Programme Development with the Department of Health and Community Services, Dr. Tom Cantwell, Clinical Chief of Mental Health Programme, Health Care Corporation of St. John's and Assistant Clinical Professor of Psychiatry, Faculty of Medicine, Memorial University, and numerous others spoke passionately of the need for resources for mental health services. Unless there is a meaningful level of resources, especially in the community, the usefulness of new legislation will be minimized.

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[21] Inquiry Exhibit DM#7, at 30-33

The priorities of service delivery will be addressed in detail under Section 5 - Issues of Health Care.

Several areas for legislative reform have been addressed. The Inquiry will not be recommending draft sections of new legislation but will outline several areas that need to be addressed. Further, I will not be recommending piecemeal amendments. Clearly a complete overhaul is required.

> "Patient rights need to be legislatively recognized.
>
> There are no provisions in the Act requiring peace officers, physicians or other health care providers to provide a person detained or subject to the Act with any information concerning the detention or review/appeal from detention. This is unique in mental health legislation across Canada.
>
> The evidence suggests that no one person or health care professional is charged with the responsibility to provide a person detained under the Act with information concerning his detention. There is no evidence that there is any consistency in the manner in which persons are informed of their status, reasons for detention or the manner in which the review board process is accessed."[22]

In defined circumstances where a person is suffering from mental disorder, a peace officer may apprehend and detain. Newfoundland and Labrador remains the only province where the peace officer must actually observe the behaviour. In all other Canadian Jurisdictions the police may act on "reasonable and probable grounds" or "reasonable grounds" or in British Columbia "from personal observations or information received."

There are two main reasons for this process. One is the timeliness factor where, in an emergency, the police can legally act quickly from reliable information received as opposed to waiting around for personal observation, which may not even happen in their presence. Secondly, it places enormous pressures on family members to have to go on the record and become an "informant" before a Judge.

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[22] Sandra Burke, Inquiry Brief, at 56.

An example of the awkwardness of s.12 of the *Mental Health Act* is recounted in the submissions by counsel for the R.C.M.P. and Constable Daley.

> "The 18 June 2000, incident is bathed in irony. First, as Nicholas Avis, Q.C., counsel for Constable John Malinay, elicited in cross-examination from Constable Daley:
>
> **Q.** .... the complaint at that time [June 2000] was that Mr. Reid was at a home with a metal pipe and wouldn't leave?
>
> **A.** .... That's correct. ... there were two aspects of the complaint initially that a threat had been made. ... and subsequent to that [,] information was provided that he was at a residence and the complaint was fearful because he was armed with a lead pipe or something to that effect.
>
> **Q.** .... you could have apprehended Mr. Reid under ... [the *Criminal Code*].
>
> **A.** .... Yes.
>
> Instead of precisely maintaining the law (as etched in French in the R.C.M.P. coat of arms, and long established at common law), in aid of the imprecise public interest, Constable Daley purported to apprehend Mr. Reid under the *Mental Health Act*, s. 12, in Mr. Reid's private interests. Secondly, Mr. Reid's behaviour, on 18 June 2000, also warranted his apprehension under the *Mental Health Act*, s. 12. Because, however, Constable Daley had not personally observed the actionable behavior - constable Daley was not authorized to apprehend Mr. Reid under the *Mental Health Act,* s.12. Because, however, Constable Daley had not personally observed the actionable behavior - he had been informed by another R.C.M.P. member who, likewise, had not personally observed the actionable behaviour - Constable Daley was not authorized to apprehend Mr. Reid under the *Mental Health Act*, s. 12. Despite the considerable contact of the Bonavista R.C.M.P. Detachment with Mr. Reid - characterized by Inquiry counsel John Byrne, Q.C. as involving a "revolving" door [Transcript. Vol. XXIV, pp. 47-53] - both Constable Graham and Constable Daley, both from the Detachment displayed patience, sensitivity and concern with Mr. Reid. They would have spent considerably less time with Mr. Reid on 18 June 2000, by simply arresting and charging him under the *Criminal Code*. Rather, they appear to have spent most of an afternoon and evening conveying him to the Bonavista

> Hospital; there waiting for him to be medicated and to be seen and certified by two medical doctors under the *Mental Health Act*; then conveying him to the Detachment; and there arranging for a third Detachment member and a Detachment cells guard to convey him to Waterford Hospital in St. John's on authority of certificates from the two medical doctors which authorized Mr. Reid's transport to, and detention and treatment at, the Waterford Hospital."[23]

Various counsel have advocated specifically for changes to ss 10, 11 and 15 of the Act. Their submissions have merit but these types of concerns were not present in the facts of this Inquiry.

Throughout the Inquiry, there was much discussion of the "revolving door syndrome" and how Norman Reid would be stabilized within the Waterford Hospital so that he was no longer certifiable. This was particularly so during the last admission and release in July 2000.

> "Dr. Jiri Niklas found himself in a position where he had to release somebody whom he knew would not take his medication and if he did not take his medication would become dangerous. Norman Reid was released under the criteria of the *MHA* but against his doctor's advice. As Dr. Niklas testified, and others corroborated his evidence, he had no choice but to release Norman Reid. Surely not a single person who attended or testified at the Inquiry would have disagreed with Norman Reid having been kept in at The Waterford. Those who spoke to this issue, including his family members, all felt this way."[24]

The certification criteria need, to be re-examined with a view to taking away the helplessness of the discharging physician, the concerns of the public, and yet all the while recognizing a patient's rights.

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[23] David C. Day, Q. C., Inquiry Brief, at 259-261.

[24] Nicholas Avis, Q. C., Inquiry Brief, at 85.

The most contentious issue before the Inquiry is the Community Treatment Order. In terms of legislative reform there is no consensus on this point, nor is it likely there will ever be.

This subject is canvassed exhaustively in the **text**, Canadian Mental Health Law and Policy, as well as in the **paper**. "Community Treatment Orders in Canada," prepared by Dr. John Hylton for his testimony at the Judicial Inquiries. This paper was received in evidence as JH #4. Policy makers are encouraged to study the **text** and the **paper** as well as the legislation particularly in Ontario and Saskatchewan, with reference also to Manitoba and British Columbia.

I refer to page 224 of the **text**:

> "With a Community Treatment Order, a person can be required to take psychiatric treatment in the community and placed on the order while in the community rather than while in the hospital. In Saskatchewan and Ontario, unlike some foreign jurisdictions, the person must have had previous hospitalization to qualify. The new Ontario section is preceded by a purpose statement, unusual in Canadian mental health legislation, aimed at clarifying with CTOs are meant to assist. The purpose section reads:
>
>> The purpose of the community treatment order is to provide a person who suffers from a serious mental disorder with a comprehensive plan of community-based treatment or care and supervision that is less restrictive than being detained in a psychiatric facility. Without limiting the generality of the foregoing, a purpose is to provide such a plan for a person who as a result of his or her serious mental disorder, experiences this pattern: The person is admitted to a psychiatric facility where his or her condition is usually stabilized: after being released from the facility, the person often stops the treatment or care and supervision: the person's condition changes and, as a result, the person must be readmitted to a psychiatric facility."

In his **paper** and his evidence before the Inquires, Dr. John H. Hylton outlined the "perceived benefits" and the "potential disadvantages", of Community Treatment Orders worked, recounted the experience to date, and set out some of the key factors which must be examined before enacting such provisions. It is fair to characterize his approach as cautious. An insightful and comprehensive discussion of these issues is found at pp 219-242 of the text. Recommendations in favour of Community Treatment Orders are found at pp 241-242.

It is not the purpose of this Inquiry to weigh all the benefits and disadvantages of the Community Treatment Orders on a universal basis. That discussion was well canvassed in the **text** and the **paper**. The mandate of the Inquiry is to make recommendations which will help prevent similar deaths in the future. This, of necessity, requires consideration of what a Community Treatment Order might have accomplished in the case of Norman Reid.

During the period from 1995-98, when Norman Reid was under a Probation Order, he was not hospitalized. Despite severe and worsening health and social circumstances from the previous decade when there was also a significant period of non-hospitalization, Norman Reid was not certified under the *Mental Health Act* during this period of Court Order.

During this three-year period he was constantly persuaded to take his monthly injection by the public health nurse. Despite extreme reluctance to do so, he did comply because he knew he had to. The probation officer told Norman Reid he had no choice. Norman Reid, while lacking overall insight into his condition, did realize that he was obliged to take his medication and he did.

When released for the first time from the Waterford Hospital in July 2000, Norman Reid was given a prescription for new atypical medication which he had been taking during his last stay. This medication, not available as a long-lasting injection, had far fewer side effects. Norman Reid was willing to agree to anything to get out of the hospital and return to Little Catalina and promised to take his medication. He left against medical advice.

Dr. Niklas had to release Norman Reid because he was no longer certifiable. The psychiatrist knew Norman Reid would not take his medications and that he would become dangerous. Within a few short weeks, Norman Reid confronted the police with an axe and was shot to death. There were no therapeutic levels of medication in his body.

Quite clearly this tragic situation would not have occurred when and how it did if Community Treatment Orders were in effect. While not co-ordinated and managed, there were sincere local efforts of significance in the past to deal with Norman Reid - family, doctors, public health nurse, probation officer. For the most part, this represented "good people working alone." The fact is that Norman Reid's health became worse and he became more dangerous.

Changes in legislation relating to a relaxation of the test for certification and a Community Treatment Order with sufficient community supports would have been helpful in averting the events of August 26, 2000.

I believe it would be unwise and unfair in a free and democratic society to enact legislation providing for Community Treatment Orders that simply snatch up mentally ill people who do not take their medication and thereby have them institutionalized. Minimum and well-defined community supports must be in place before such legislation is in effect.

Dr. Hylton's paper alerts us to this when he stated at pp 13-14:

> "Enhanced community services are seldom developed in tandem with the introduction of new Community Treatment Order schemes."

Again at p.9:

> "Some have gone so far as to suggest that Community Treatment Order legislation is a convenient way for governments to respond to family and community concerns without addressing the root problem of inadequate resources for community health services."

The Stella Burry Corporation under the leadership of Jocelyn Greene has done excellent work in St. John's. Our hearts were moved as she recounted the dramatic positive results in the lives of three women and one man. Ms. Green and Moyra Buchan, Executive Director, C.M.H.A., are opposed to Community Treatment Orders preferring to work with people rather than coercing them. Their view is that with the right approach, to have early intervention, community supports, appropriate medication and assertive case management.

John Collins, who is now a resource centre co-ordinator with the C.M.H.A., has been diagnosed with schizophrenia. He first became ill at the age of eighteen. His personal reflections were well received - his insight, refreshing and valuable. An excellent ongoing relationship with his psychiatrist has really helped him one medication regime to the next. John Collins has returned to an older drug, Largactil, having tried the newer atypical anti-psychotic Risperidone (Risperidal). Mr. Collins advised us that most consumers in Canada are opposed to Community Treatment Orders.

In the recommendations to follow, I will be supportive of Community Treatment Orders in new legislation for Newfoundland and Labrador - but only as a last resort and only when issues of patients' rights, timely reviews, confidentiality of records and effective and sufficient community supports have been put in place. The legislative scheme I will be recommending will not in any way be casting a wide net to catch high numbers of noncompliant mentally ill persons.

We have been told that there is no provincial reporting system which would provide us with reliable accurate statistics. Based on evidence at the Inquiry including statistics from Saskatchewan, Ontario and New Brunswick, plus observations from our own Province, it is my impression that there are no more than forty and possibly as low as twenty-five mentally ill persons in Newfoundland and Labrador who are dangerous to others, have had several admissions to hospital, and who are frequently noncompliant with taking their medications.

It is my view that Norman Reid, largely due to his worsening illness in the late 1990's and his culturation based on isolation, family violence, and limited education, would not have fared well with assertive case management. Further, even with effective early psychosis intervention, better medications and assertive case management there will still be a few individuals who for the sake of the safety of others and sometimes also themselves, will need to be subject to Community Treatment Orders.

> "Having stated the same, it has been the experience of the Reid family that when Norman was under the impression that he was subject to a Court Order to take his medications between August of 1995 and December of 1998, he did. In Addition, he had little or no involvement with the police during

> the same corresponding period, again confirming the position of many of the proponents of CTO's."[25]

I believe it is unrealistic to think that assertive case management teams can be set up in every corner of rural Newfoundland and Labrador. It will not be possible to give the same attention to persons in Little Catalina or Bonavista as it would be in St. John's. Transportation for team members or for reluctant patients is always going to be a very real consideration.

In the end, there will always be a few individuals who judiciously will have to be placed on a Community Treatment Order. These are seriously ill people, like Norman Reid, who will not respond to the type of persuasion described by Moyra Buchan and Jocelyn Greene. It is simply unacceptable to have them aimlessly adrift in despair, lacking insight and posing a serious threat to the safety of others.

To blindly and without restriction have honoured the personal freedom of Norman Reid did not help him. A little knowledge in the mind of a very sick man with no insight was a dangerous thing. In August 1999, twelve months before his death, Norman Reid told Dr. Ladha that "I will only take my pills if I feel like it, and that no one can make me."

In the above commentary, many areas of mental health legislative reform have been addressed. I will be recommending in the strongest possible terms with specific time frames the enactment of a new *Mental Health Act*. There is no shortage of research nor position papers. The list in Exhibit DM #7, is impressive. What is not impressive is the lack of action.

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[25] Thomas E. Williams, Inquiry Brief, at 10.

In the 23 years since the Hagan Inquiry, there have been at least 11 people who have served as Minister of Health - from both major political parties. What is often cited as a lack of a consensus should be properly understood as a clear lack of will and leadership which cannot in any way shield us as people from a distinct moral obligation to provide justice, in the largest meaning of that word, to those who are mentally ill.

4.2 *Neglected Adults Act*

At the Inquiry there was considerable discussion about the scope, applicability and non-utilization of the *Neglected Adults Welfare Act* (1990), R.S.N.L. c. N-3.

> "The evidence of Mr. Allan Corbett, Manager of Adult Programs with HRE, indicated that while the Act may appear to cover mental illness it was never designed for that purpose but for the elderly who are unable to help or care for themselves. He said that would require a complete overhaul of his department and he would require expertise and staffing."[26]

> Counsel for the family submitted Norman Reid was clearly a neglected adult.

> "While the Act has virtually remained unchanged since its original conception in 1971, and has been interpreted so as to be fundamentally applied to seniors, the provisions of the Act can be demonstrated to be wider in scope. When one examines Section 2(I) of the Act, we see four preconditions in order to be constituted as a Neglected Adult.

(I) "neglected adult" means an adult
  1. who is incapable of caring properly for himself or herself because of physical or mental infirmity;
  (ii) who is not suitable to be in a treatment facility under the *Mental Health Act;*
  (iii) who is not receiving proper care and attention; and
  (iv) who refuses, delays or is unable to make provision for proper care and attention for himself or herself;

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[26] Nicholas Avis, Q. C., Inquiry Brief, at 86.

When one considers these four conditions in light of the personal circumstances in which Norman Reid found himself (i.e. no heat, no light, no running water, etc.), Mr. Reid should have been regarded as the epitome of a neglected adult. This point was not only borne out during the course of this Inquiry, but in fact was highlighted as far back as 1996 in a letter from registered nurse Sheila Hancock, wherein she outlined her concerns in correspondence addressed to the Department of Social Services."[27]

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[27] Thomas E. Williams, Inquiry Brief, at 96-97.

Following is the letter of Sheila Hancock (Exhibit SH #1). (Reproduced for legibility.)

COMMUNITY HEALTH
Eastern Region

P. O. Box 278
Bonavista, NF,
AOC 1B0

September 05, 1996

Ms. Sylvia White
Department of Social Services
Bonavista, NF.
AOC 1B0

Dear Mrs. White:

I would like to reiterate my concerns for our mutual client, Mr. Norman Reid, some of which we previously discussed by phone.

Norman was discharged from the Waterford Hospital August, 1995. Upon his arrival home, he was informed by your co-worker, Mr. Snook that repayment of his monthly allowance for the period of confinement was necessary. Consequently Norman's meager allowance is still reduced by $19.00 per month to meet this objective.

Norman's electricity was cut earlier in 1996 because he owed in excess of $500.00 to Nfld. Light and Power. This certainly detracted from his already minimal quality of life. During the winter months, especially, his health and safety was at risk and continues to be by his use of candles and lanterns. He has an oil stove that rarely has enough oil to last a month in the colder months. The condition of the home itself, uninsulated, etc. probably is a factor here.

Presently Norman's lack of intact footwear is a concern. Is a regular apparel allowance available?

Mr. Reid's only source of diversion at home is a battery operated radio.

As you probably know, Norman has no source of nurturing or encouragement; no job or involvement that could boost his self-esteem and keep him occupied. He is not welcomed and very often shunned by his relatives and neighbours - not a very positive social situation.

From my comments you can see that concerns for Norman touches all areas of his life. I have written in the hope that your department may have knowledge of, or access to, some program or funds to address any of the problems mentioned.

Sincerely,

Shelia Hancock, RN

SH/dn

OFFICES
Bay Roberts, Bonavista, Burin, Carbonear, Clarenville, Come By Chance, Conception Bay South, Grand Bank, Harbour Grace, Heart's Delight, Holyrood, Norman's Cove, Old Perlican, Placentia, St. Bride's, St. Joseph's, St. Lawrence, St. Mary's, Trinity, Whitbourne

With regard to this Act, clarification into its nature, scope, and related policy is desperately needed. If the Act is not going to apply to mentally ill persons, like Norman Reid, then simply amend the Act and restate policy. It is my view that we do not need any duplication of service and that mentally ill people should be afforded the services they need outside of the *Neglected Adults Welfare Act*.

4.3 *Fatalities Investigations Act*

Section 5 of the *Fatalities Investigations Act*, SNL 1995, c. F - 6.1, states in part:

> **5. A person having knowledge of or reason to believe that a person has died under one of the following circumstances shall immediately notify a medical examiner or an investigator:**

The use of the word "immediately" in section 5 has caused some concern. It seems to me that the use of the words "forthwith or as soon as practicable" from the Criminal Code s.254(3), which has been already interpreted by various Courts, would better address the situation presented here.

4.4 *Advanced Health Care Directives Act*

While not directly related to the life of Norman Reid, the issue of ambiguity in s.2(b) arose. That section states:

> **2(b) "Health Care Decision" is defined as "a consent, refusal to consent . . . of any care, treatment, . . . medication, or procedure to maintain, diagnose, treat, or provide for an individual's . . . mental health . . . and includes . . . psychiatric treatment for a person who has not been admitted under s.5 of the Mental Health Act to a treatment facility, the administration of nutrition and hydration and admissions, other than under s.5 of the Mental Health Act, to treatment facilities and removal from those institutions."**

It is highly unlikely that Norman Reid would have put into effect an advanced health care directive. However, the position outlined in Exhibit DM #7, at p. 34, makes sense in that it would "allow people with mental illnesses who are involuntarily certified to a hospital to have their directives followed, if not in conflict with the law."

5. Issues of Health Care

5.1 Health Care Corporation of St. John's

a. Past Services

The Inquiry will not be analyzing the services offered to mentally ill persons in the past except insofar as they may have affected Norman Reid. Considerable time was spent reviewing the thirteen admission files of Norman Reid at the Waterford Hospital and it appears that the multi-disciplinary services offered to Norman Reid while hospitalized were appropriate.

There may have been isolated incidents such as those of March 1978 involving a phone call to his sister from the General Hospital, his transport to the Waterford Hospital and the skepticism of the staff as to what Norman Reid was observing, where the appropriateness of the care might be called into question; however, there was no opportunity for staff to respond. Norman Reid was unknown to them and had been violent to the point where he had to be transferred from the General to the Waterford.

Overall, given the long time frame under examination, 1978 to 2000, Norman Reid "received appropriate care and treatment while admitted to the Waterford Hospital."

Norman Reid was stabilized to the point that he was no longer certifiable and released to the Community. Several people in Little Catalina observed that shortly after his return home after the later discharges he seemed no better and possibly was even worse than before. This, per se, is not the fault of the hospital as it was of the overall mental health system.

In fact, if one were to examine, for example, the 11th admission file, it is readily apparent that hospital staff made considerable efforts in June and July of 1999, to bridge the gap between institution and community. The Department of Human Resources and Employment was written and called. Discharge planning was totally frustrated by Norman Reid's hostility and unwillingness to be helped by the community. These problems have been addressed in earlier chapters.

b. Present and Future Services

The Mental Health Programme has approximately 1600 admissions each year, of which about 400 are from outside the greater St. John's area. With the emphasis on deinstitutionalization over many years, the number of acute care beds at the Waterford Hospital at the end of 2002, was 62. At the Health Sciences Centre the number was 22 with a possible increase to 28. The multi-disciplinary team approach has been in effect for quite a while.

Witnesses at the Inquiry, Colleen Simms and Dr. Tom Cantwell have co-chaired a Task Force on the Restructuring of Acute Care Services. This group was well represented - C.M.H.A., C.H.A.N.N.A.L., Schizophrenia Society, Health Care Corporation and Department of Health and Community Services.

Four laudable initiatives of the Task Force are outlined in the submission of the Health Care Corporation of St. John's.

99. "It was recognized by the Task Force on the Restructuring of Acute Care Services that acute care inpatient services do not meet the needs of all patients and so a decision was made to create a program which would be more accessible to a larger group of individuals and accordingly a program known as the START Clinic was created. That clinic offers short term therapy on an outpatient basis for up to a six appointment times. This program is intended as a bridge for the gaps in acute care services both for impatient and outpatient services. In other words, this program is intended to broaden the continuum of acute care services being provided by the Mental Health Program of the Health Care Corporation of St. John's.

100. The START Clinic is an inter-disciplinary team which will include three psychiatrists, three psychiatric nurses, one social worker, two psychologists and an occupational therapist. That clinic was due to being on December 2, 2002.

101. The impetus for the START Clinic was the recognition that some patients had difficulty obtaining appointments with a psychiatrist or to get in to see a psychiatrist on an emergency basis. Prior to the START Clinic, it has been difficult for a patient seen in emergency to secure an appointment with a psychiatrist in St. John's and on occasion it has taken months to obtain an appointment. This clinic will now bridge that gap.

102. Another proposal from the Task Force on the Restructuring of Acute Care Services was the creation of a Psychiatric Emergency Service which is currently located within St. Clare's Hospital but it is intended to move to the Health Sciences Centre. The Mental Health Program of the Health Care Corporation of St. John's has secured funding to keep a psychiatric nurse in the Emergency Department 24 hours/day, 7 days/week. It is intended that the psychiatric nurse will see the clients first, do the assessments, work with the Emergency Department physician on whether a psychiatric consult is required and then follow up with the individual and connect them with services in the community where necessary.

103. Another of the proposals of the Acute Care Restructuring Task Force was to create the position of Consultation Liaison Nurse whose duty it is to consult with patients with mental health problems who are in some other ward of the Health Care Corporation of St. John's. Many times there are ongoing mental health issues among patients who are in other departments such as medicine, surgery, critical care, ICU, etc. The Consultation Liaison Nurse (who is a psychiatric nurse) will follow such patients in a ward outside of the Mental Health Program. As of December 2002, the Consultation Liaison Nurse worked within St. Clare's Hospital but there were plans in the works for that position to be replicated at the Health Sciences Centre.

104. The fourth proposal of the Task Force on the Restructuring of Acute Care Services was for a Community Health Nurse position, based out of the Waterford Hospital site, whose function it is to follow patients in the community after their discharge from acute care. The Community Health Nurse is based out of the Waterford Hospital site and he/she follows patients from the acute care unit after their discharge in the St. John's region. They will also follow up by telephone calls with patients residing outside of the St. John's region.

> 105. All of the above positions have been filled as of December 2002."[28]

Many other valuable and worthwhile programmes in the St. John's area were brought to our attention. For example, the Psychiatric Rehabilitation Interdisciplinary Team includes two nurses, a psychologist, an occupational therapist, a pastoral care provider, a recreational therapist, a social worker and a job opportunity's officer. Philomena Kavanagh spoke highly of this programme, which had provided help to her daughter, Jill Kavanagh, diagnosed with schizophrenia.

> 116. "The services provided by the case managers within the Psychiatric Rehabilitation Interdisciplinary Team include supportive counselling, crisis prevention and intervention, assistance with managing symptoms and behaviours, health and medication teaching and monitoring, teaching community living skills, finding suitable housing, advocacy on behalf of patients and families, family support and education."[29]

Other important programmes include Family Care, Community Care, Terrace Clinic (clinic offering psychotherapy and counseling services free of charge, away from the Waterford Hospital), Day Treatment (formerly at the General, planned transfer to St. Clare's), Mill Lane and Evergreen Recycling (occupational therapy), Meeting Place (leisure activities), and Family Support Groups.

> "Perhaps the most exciting innovation in recent years is the Early Psychosis Intervention Program, sited at the Waterford Hospital. This approach is based on research findings that treatment with atypical anti-psychotics as early as possible during the first onset of psychosis, coupled with intensive

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[28] Robert Dillon, Inquiry Brief, at 24-26.

[29] *Ibid.* at 28.

social support and family education, substantially improves the outcome for the young people affected. In this way, both the neurobiological damage caused by prolonged psychosis and the disruption of the young person's life at a crucial developmental stage can be greatly reduced. The goal is to provide treatment in the community and, as much as possible, prevent admissions to hospital.[30]

An outline of the programme follows:

118. The Early Psychosis Program is a relatively new program at the Waterford Hospital which deals with patients who are experiencing a psychosis for the first time. The case management model used in the Early Psychosis Program is somewhat different from the other programs insofar as that in order to be a part of this program, it is mandatory for the patient to have a case manager. That is, with the other programs such as Community Support Program and Psychiatric Rehabilitation Interdisciplinary Team, the patient may refuse to participate in the program or may refuse the services of the case manager. Whereas, the case managers in the Early psychosis Program will continue to follow individuals who are refusing treatment and they are keeping in touch with them and their families regardless of consent, which is part of the program's mandate.

119. The Early Psychosis Program uses a multi-disciplinary team approach and it provides services such as medication strategies, psychotherapy (individual and group), occupational therapy, recreational therapy, spiritual counselling and family support.

120. As of December 2002, there were 80 patients in the Early Psychosis Program.[31]

The Inquiry is encouraged by developments at the Health Care Corporation of St. John's.

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[30] Sandra Burke, Inquiry Brief, at 79.

[31] Robert Dillon, Inquiry Brief, at 29.

5.2 Other Health Regions

Regrettably, most of the innovative programming in St. John's is not available elsewhere. On the Bonavista Peninsula, there are no psychiatrists. That service, already strained, is available in Clarenville. Generally, this shortage is a major problem throughout the Province. While the Peninsulas' Health Care Corporation is able to provide physicians, nurses, social workers, counselors, etc. to the Bonavista Area, there are not, for the mentally ill, any case management teams, assertive or otherwise.

Nonetheless, there is some collaboration between the regional hospital and community services:

> "In recent years sixteen persons with mental illness have been granted home support services under the Enriched Needs Program in East Region, notwithstanding the restrictive criteria, because it was the only way to enable them to stay in the community. Such collaboration, however, requires time and energy on the part of the workers involved, as well as cooperation by the individual. In the case of Norman Reid, the dedication of Sheila Hancock was not in itself sufficient to move the service system beyond its established boundaries. Norman, perceived as difficult and uncooperative, fell right through the gaps."[32]

A refreshing response to meeting needs in an area of uncompromising geographical challenges was made to the Inquiry by Deanne Costello, Social Worker with the Grenfell Regional Health Services Board. This is an Integrated Board - Hospital and Community Services are administered under the same roof. Communication problems and frictions which may exist in other regions are much less here. They effectively serve a population of 17,000, spread throughout 83 communities. At the time of her testimony in November 2002, there was a mental health caseload of approximately 65, on an outpatient basis, of whom five or six would be considered dangerous to some degree.

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[32] Sandra Burke, Inquiry Brief, at 80.

There is a strong multi-disciplined team approach despite some staffing obstacles. For example, the health educator's time is only one third for mental health, and Ms. Costello herself, who has served as team leader, is only half time. The team consists of the above noted health educator and social worker, psychiatric practical nurses, four mental health registered nurses (one in Forteau, one in Flower's Cove and Roddickton, two in St. Anthony), a psychologist and a psychiatrist.

Comprehensive Community Services include a day programme (relaxation therapy, social skills and crafts), community development (public education, school drama, newspaper articles), protocol with R.C.M.P. on the subject of apprehension, frequent and informal clinical meetings, advocacy, liaison with community groups, therapeutic crisis intervention, etc.

A definite part of their "work culture" is to travel, see the people that need to be seen, and "get the job done." This is a delightful example of a locally driven initiative providing a focused co-ordination of services.

5.3 Assertive Case Management

Throughout the Inquiry, witnesses who were asked about possible improvements to the delivery of mental health services in the community invariably recommended multi-disciplinary team management of individual patients. This approach is already taken within the institutional setting, the Waterford Hospital, but only in very limited situations in the community do we have case management services. Outlined above was the model from the Grenfell Board and reference has been made to the only assertive case management system in the Province, Stella Burry Community Services in St. John's.

Whether assertive or otherwise, models could include some of the following: psychiatrist, psychologist, nurse, social worker, occupational therapist, educator, counselor, family members, family physician, police.

> "A consistent recommendation of witnesses from the mental health professions was that case management services be provided to persons with severe and persistent mental illness living in the community. This service plays the role of coordinating services and communication among all those involved in providing care and support, both in hospital and in the community, including consumer, family psychiatrist, social worker, counsellor, etc. The effectiveness of case management in helping a person access the services they need in a timely way is well documented in the literature. This involves adjusting services as required, ensuring increased support at times of difficulty, and intervening quickly to obtain psychiatric treatment when a relapse occurs. People with case managers know who to contact when their needs or circumstances change, and are generally able to maintain significantly greater stability in their health than those without this service. In her presentation, Colleen Simms described the investment of the St. John's Mental Health Program in case management and the role these works play in various settings to monitor and respond to the needs of their clients.
>
> It should be noted that for many people with mental illness in this province, family members in effect play the role of case managers. Those who have no such support are much more likely to get caught in the Revolving Door Syndrome.
>
> For the small number of people who, like Norman Reid, are resistant to accepting treatment or have very complex needs and issues, the Assertive Case Management model has been identified as a best practice. Assertive Case Management differs from the type described above in that case numbers are very low (around ten). Ms. Simms' submission states:

> Assertive case management lends itself to providing support to the most severely compromised mentally ill individuals. These individuals may be noncompliant, psychotic, have little insight and may be reusing all services. Assertive case managers often work in teams; they case manage no more than ten individuals. They frequent their clients' neighbourhood and provide support as needed. If all services are refused by the client, they will continue to monitor the person and ensure they are okay. Assertive case managers can administer medications or give cigarettes, whatever the need. They are focused on the individual and are multifaceted in the services they provide (p.23).

There is only one agency in the province that has developed the capacity to provide Assertive Case Management. Stella Burry Community Services (SBCS) in St. John's has undertaken responsibility for serving some individuals with highly complex mental health needs, people who have spent many years cycling in and out of psychiatric hospitals and correctional institutions. In her evidence to the Inquiry Jocelyn Greene, Executive Director of SBCS, described their success in helping people who had spent years in custodial care adjust to living in the community. Critical to this success has been the ancillary outreach or home support service. Home support is provided by nonprofessional workers who work closely with the case manager to offer the kind of support the consumer needs, whether this is help with shopping and cooking, accompaniment to doctors' appointments, or encouragement to get involved in community activities. Ms. Greene described this as a process of building relationship and creating trust, respecting the wishes of the individual but never giving up on them.

The work of SBCS in this area was originally a pilot project funded through Corrections Canada. As a result of intensive advocacy (sometimes by consumers themselves), responsibility for supporting the home support component of the service was assumed by Health and Community Services, St. John's Region. Recognizing the unique accomplishments of the pilot program, HCS St. John's has designated Stella Burry Community Services a Mental Health Home Care Agency, the only one of its kind in the province. SBCS is continuing its trailblazing work in this area with new federal project funding to establish a Community Outreach Centre, where the diverse services used by their clients can be effectively coordinated.[33]

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[33] Sandra Burke, Inquiry Brief, at 82-83.

6. Social Support

6.1 Income and Home Care

While it is true that for the last several years of his life, Norman Reid lived in abject poverty, the provision of more income of itself would have done little to enrich his life. With no insight into his severe mental illness, he was not, on his own, capable of managing his financial affairs. He was not well enough to want people, no matter how skilled and well-intentioned, "interfering" with his life.

That is why it is essential that well-informed, experienced case managers be in place to watch over and help severely mentally ill persons, respecting their individual freedoms as appropriate in each situation. I am not suggesting in any way that extra funds be available to be squandered on various items including junk food, alcohol and tobacco. The reality of the very high prevalence of smoking amongst those with chronic mental illness was somewhat disturbing, although not totally surprising. Norman Reid favoured tobacco to food and electricity. A dedicated, skillful case manager would be in a position to bring about a careful but understanding approach to balance the issues of budgeting and individual liberty.

There is merit to the position put forward at the Inquiry that severely mentally ill persons be afforded the same social benefits as persons with severe physical or developmental disabilities. Of course, that is not to say that the latter groups of people have their benefits reduced, but rather that the former be treated similarly. Specifically, the provisions of hours for home support service, more generous rent and utility allowances, and the flat rate allowance should be provided without discrimination. It may not be possible to implement this policy immediately; however, a responsive and responsible time frame should be set out and followed.

In his final report, November 2002, *Building on Values - The Future of Health Care in Canada*, Commissioner Romanow specifically identified home care as a priority for those with mental illness.

At page 172, he wrote:

> "Because of the significant costs that would be involved in including all home care services under the *Canada Health Act,* priorities should be placed on the most pressing needs. There is little doubt that effective home care support is vitally important to people with mental illnesses, to people who have just been released from hospital, and to those who are in their last months of life. These three areas - mental health, post-acute care, and palliative care - should be the first three home care services to be included under a revised *Canada Health Act*."

After referring to mental health often being described as one of the "orphan children" of medicare, Mr. Romanow stated at page 179:

> "Recent history has shown that the trend to treating people with mental illnesses in their own communities rather than in institutions has not been accompanied by sufficient resources. Many mental health patients were discharged with insufficient resources and networks to support their ability to live at home. Often, to be eligible for home care, a person had to have a physical disability or difficulties with activities of daily living. These requirements preclude many people with mental illnesses from accessing necessary home care interventions and support. According to the Canadian Mental Health Association (2001), one of the main lessons to be learned from this failed experiment is that clinical services must be in place in the community before hospital beds are closed.
>
> In the case of mental illnesses, home care is not simply an alternative to institutionalization. Treating people effectively in the community rather than in institutions or hospitals *requires* home care, particularly in order to ensure

> that people with mental illnesses continue to take their medications appropriately and do not need repeated re-admissions.
>
> In addition to improving care and support for people with mental illnesses, providing case management and interventions when needed is also a cost-effective approach. It not only precludes the need for people to stay in institutions but it also prevents the high costs of continuous re-admission to hospitals or other facilities. In many cases, a home care client may have a brief episode of unmanageable behaviour in the home and institutionalization will occur immediately. By focusing home mental health care on people who generally live well in the community, but who may have occasional problems, recurrent institutionalization can be prevented or minimized, and very large savings to the system can be realized (Hollander and Chappell 2002).
>
> Two types of home care services should be available for people with mental health problems. The first is case management, in which a case manager would work directly with the individual and with other health care providers and community agencies to monitor the individual's health and make sure the appropriate supports are in place. This would ensure both continuity and coordinator of care. The second is home intervention to assist and support clients when they have an occasional acute period of disruptive behaviour that poses a threat to themselves or to others and could trigger unnecessary hospitalization."

Many of the issues studied at the Inquiry and written in this report have already been examined by the provincial government in detail including these crucial areas of home care and other supportive services. Particular attention should be paid to *Healthier Together, A Strategic Health Plan for Newfoundland and Labrador, 2002,* at pages 24 and 25.

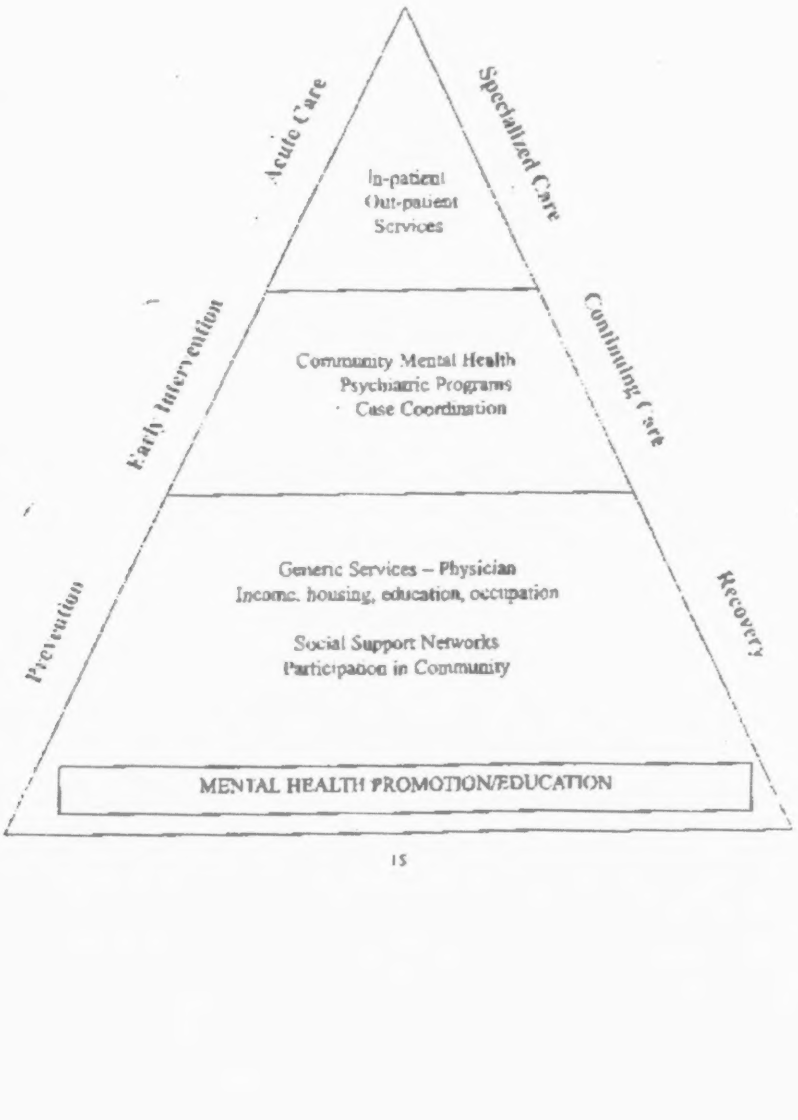
Within that document, reference is made to, *Valuing Mental Health, September 2001,* which was prepared by the Newfoundland and Labrador Division of the C.M.H.A. - a paper that "captured the spirit and intent" of many stakeholders.

My report must be read in conjunction with these two provincial papers never losing sight of that simple but profound triangle found on page 15 of this Service Framework.

A. Service Framework

A SERVICE FRAMEWORK

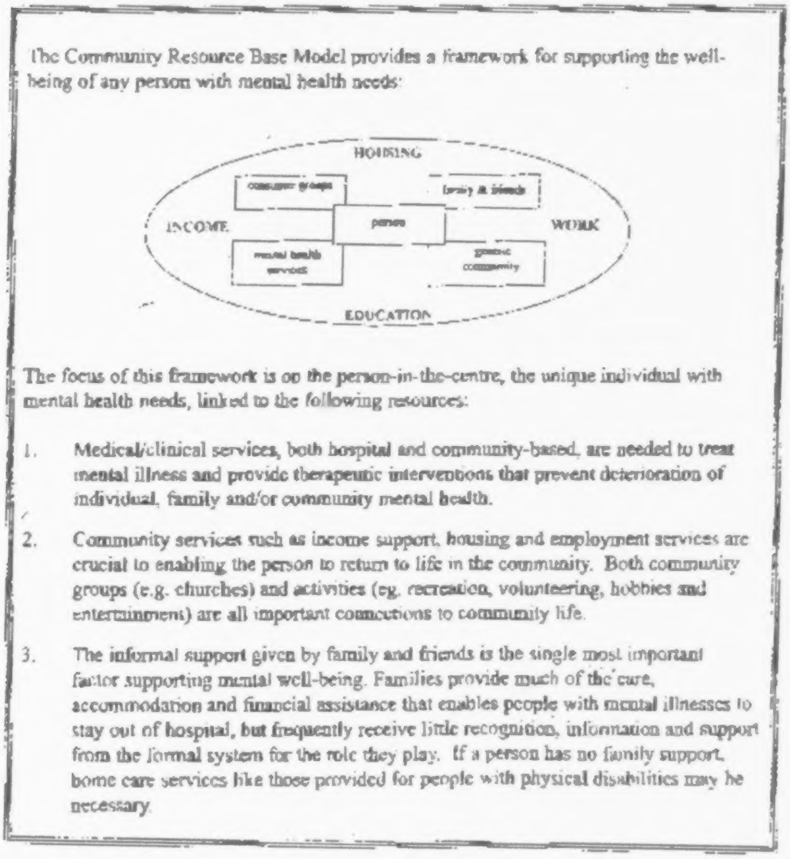
The following diagram shows the different levels of service that are needed to support mental health and well-being, prevent avoidable problems and crises, treat illness and enable recovery.


Acute Care
Specialized Care
In-patient
Out-patient
Services
Early Intervention
Continuing Care
Community Mental Health
Psychiatric Programs
Case Coordination
Prevention
Recovery
Generic Services – Physician
Income, housing, education, occupation
Social Support Networks
Participation in Community
MENTAL HEALTH PROMOTION/EDUCATION

Also, reference should be constantly made to the ellipse and commentary set out below.

The Community Resource Based Model

THE COMMUNITY RESOURCE BASED MODEL



The Community Resource Base Model provides a framework for supporting the well-being of any person with mental health needs:

HOUSING
consumer groups
family & friends
INCOME
person
WORK
mental health services
general community
EDUCATION

The focus of this framework is on the person-in-the-centre, the unique individual with mental health needs, linked to the following resources:

1. Medical/clinical services, both hospital and community-based, are needed to treat mental illness and provide therapeutic interventions that prevent deterioration of individual, family and/or community mental health.
2. Community services such as income support, housing and employment services are crucial to enabling the person to return to life in the community. Both community groups (e.g. churches) and activities (eg. recreation, volunteering, hobbies and entertainment) are all important connections to community life.
3. The informal support given by family and friends is the single most important factor supporting mental well-being. Families provide much of the care, accommodation and financial assistance that enables people with mental illnesses to stay out of hospital, but frequently receive little recognition, information and support from the formal system for the role they play. If a person has no family support, home care services like those provided for people with physical disabilities may be necessary.

6.2 C.H.A.N.N.A.L.

The background and purpose of Consumer's Health Awareness Network, Newfoundland and Labrador (C.H.A.N.N.A.L.) is set out in the C.M.H.A. brief.[34]

> "C.H.A.N.N.A.L. was founded in 1989 by a group of mental health consumers who came together to talk about their experiences and concerns. With the administrative support of the Canadian Mental Health Association, Newfoundland and Labrador Division, the organization has expanded into every region of the province. It supports clusters of self-help groups where people with mental illnesses of various kinds provide support and understanding to each other. Some groups focus on specific illnesses such as bipolar disorder or anxiety, while others are mixed, non-diagnostic groups. The provincial network comes together once each month via the teleconference system.
>
> Self-help is an enormously valuable resource which is proven to boost self-esteem and personal coping on the part of many participants, as well as creating friendship and community. It is not, however, a permanent activity for most people: it serves an important purpose in supporting recovery, but at some point most individuals want to move on with their lives.
>
> Those who stay involved with the self-help movement on a long-term basis usually do so as advocates and educators. Out of every group, one or two people emerge who want to improve the mental health care system and to banish stigmas by educating the community about the experience of mental illness. John Collins exemplifies this response. He and fellow-consumers play an important role on policy and planning committees and in university and high school classrooms, bringing the directness of experiential knowledge to the subject and maintaining a reality touchstone."

We heard from Sherry Northcott, a provincial coordinator of C.H.A.N.N.A.L. up until May 2002. She told us that there are at least 200 people in the province who participate in this very loose network run by consumers. There are approximately 14 different groups in the province. The coordinators help run the group meetings, usually 4 - 15 individuals in attendance. She was not aware of ever having to call in the police. Unfortunately, funding has always been a problem and is clearly an issue which needs to be addressed.

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[34] Sandra Burke, Inquiry Brief, at 88.

Neither Norman Reid nor Darryl Power partook in any of these meetings. Neither they nor their families were aware of C.H.A.N.N.A.L. or the C.M.H.A..

6.3 Canadian Mental Health Association

Newfoundland and Labrador Division

The C.M.H.A. through its counsel, Sandra Burke, and its executive director, Moyra Buchan, has been very helpful to the Judicial Inquiries into the sudden deaths of Norman Reid and Darryl Power. Again I would refer to the C.M.H.A. submissions.

> "The Canadian Mental Health Association, Newfoundland and Labrador Division (C.M.H.A.), is a small organization with a vast mandate: to promote the mental health of all people in the province. Governed by a volunteer board, it has three staff members and a separate Foundation which is responsible for fund-raising activities. Some four thousand volunteers, assist with fund raising, while others work on committees and projects.
>
> C.M.H.A.'s primary activities are in the areas of public education, advocacy and community development. The provincial office in St. John's is often the entry point for people with questions about mental health or mental illness, and handles thousands of requests for information and referral every year, including numerous distress calls and visits. Educational seminars on the different mental illnesses, stress management, and issues related to the mental health system are delivered to University classes, high schools, workplaces, professional and community groups.
>
> C.M.H.A. representatives sit on policy and planning committees of government and health boards, provide mental health consultation to other organizations and projects, and address mental health issues of public concern in the media.
>
> C.M.H.A. also leverages federal funding to support community development projects such building the provincial mental health consumer network, responding to the impact of the Cod Moratorium on communities, developing the helping skills of people in communities, and creating support networks for families of young people with psychosis, to name just a few initiatives."[35]

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[35] Sandra Burke, Inquiry Brief, at 88-89.

The work of the C.M.H.A. here is widely recognized and was specifically cited in the Romanow Commission final report, being highlighted at page 179.

> "People with mental illness are excluded from home care and home support services - unlike people with physical illnesses or disabilities - and these would make an enormous difference to their health."

While neither Norman Reid nor Darryl Power nor their families availed of the services of the C.M.H.A. prior to the two tragic deaths, there can be little doubt that at many times in their lives these supports would have proven beneficial.

7. Issues of Policing

7.1 Training

a. Use of Force Continuum

Over the course of time, police forces in Canada have developed and reviewed use of force models and the requisite training. These programmes are updated constantly and reviewed by the legal branches as well as educational methodologists.

The R.C.M.P.'s Incident Management/Intervention Model (IMIM), was established in 1994, with acceptance and implementation in 1997. This model is part of a larger programme consisting of 70 sessions on police defensive tactics. An overall principle is that the "officer continuously assesses risk and applies the necessary intervention to ensure public and police safety." Not only does the IMIM colour graphic present well, it makes abundant sense especially as one reads through the ten page guide updated as recently as October, 2002.

Even before IMIM is taught, R.C.M.P. cadets are educated on the CAPRA problem solving model (Clients Acquiring and Analyzing Information Partnerships Response Assessment).

IMIM is the national initiative of the R.C.M.P.. The National Use of Force Framework which was approved about three years ago by the Canadian Association of Chiefs of Police differs somewhat from IMIM. The differences are subtle. Both models serve Canadians well.

The Inquiry was told in detail of the "Tachy Psyche Effect" which is a "slowing down of the thought process brought on by severe stress." Certainly, the standoff with Norman Reid brought about this effect to the three incident officers.

The effects listed in Exhibit DK#6, which might be experienced to varying degrees include:

1. Fine finger movement
2. Decision making degraded
3. Mental track lost
4. Tunnel vision
5. Auditory exclusion
6. General muscle tightening
7. Time/space distortion

In times of "severe stress" such as this, each officer must rely on his training and his partner.

Remember that throughout each incident, officers are continuously assessing risk in a highly volatile situation - an entirely different type of setting than a judicial inquiry months after the fact where we have the luxury of time, preparation and experts to analyze in full detail what took place over the course of a few short minutes.

The officers were trained well in this area of use of force. Their training was utilized and no major fault was found by the experts. Departures from the training which I have earlier referred to as "imperfections" included the inappropriate attempts with pepper spray and the baton.

By following their training, there were no injuries or deaths to themselves nor to any citizens, save Norman Reid who left his bridge, moving quickly toward Constable Graham, threatening to kill him with the axe.

b. Mental Illness

Virtually all witnesses who came into contact with Norman Reid, except of course for those who directly provided mental health services, expressed willingness and desire for more training in the area of mental health and dealing effectively with mentally ill persons. This was true of the adult probation officers, nurses, police officers, social workers, family members, etc. It would also be true for judges, lawyers, community leaders - and the list goes on.

In this Inquiry, the focus was on what training the police ought to have had. It is fair to say that this type of training has varied from non existent to less than adequate. All three R.C.M.P. incident officers welcomed the idea of more and better training.

We have heard from the O.P.P., the R.N.C. and R.C.M.P. of recent training initiatives. The police training videos presented to the Inquiry by the R.C.M.P. and O.P.P. (RM #9 and RH #3) show that progress is being made. There is practical teaching in these videos, both of which were produced in the last two or three years by the Niagara Regional Police Service Video Unit.

Relying on mental health professionals and police officers with considerable experience, these videos offer sound advice including the following: (adopted for each particular encounter)

- firm but gentle voice
- no deception
- no humour
- speak respectfully
- ask specific questions
- don't rush, oftentimes there is no time limit
- don't argue about how they feel

- be sympathetic
- no sudden movements
- explain why you are armed and in uniform

Through the use of these videos, group discussion, role playing, teaching by mental health professions and local service providers, and other educational techniques, recent police graduates will be better able to deal with mentally ill persons. It is important that this type of training be made available without undue delay to all police officers, especially to those in the field.

It is not expected of police officers to be able to make a diagnosis of a particular mental illness, but as a well informed, educated layperson, a peace officer would know various symptoms of mental illnesses and be able to properly conclude that the person is apparently disordered to the point that he or she needs appropriate medical attention and, if dangerous, needs to be apprehended.

What was particularly encouraging about the police approach to training in the area of mental illness and appropriate response was:

1) an acknowledgment of inadequate training in the past;
2) a willingness to continue the progress already made; and
3) establishment of liaisons with mental health service providers.

The R.C.M.P. has placed considerable importance on the text referred to earlier, *Mental Health Law and Policy*, and utilizes educational methodologists to constantly evaluate the utility of their training programmes. Furthermore, senior management is always trying to improve training and regularly looks to the national and international scene for ideas. Indeed, with the recommendations to follow, the R.C.M.P. will be provided the opportunity provincially to do just that.

Even if the three incident officers had the best of all presently available training, it is mere speculation as to whether or not the result here would have been any different given the very serious mental illness of Norman Reid and his violent nature.

7.2 Less Than Lethal Weapons

I want to emphasize again that the subject of less than lethal weapons has not been the main focus of the Inquiry. We have heard about a number of intermediate weapons including:

1. Sock round shotgun (beanbags)
2. Goo gun (sticky foam)
3. Sawed-off shotgun (tear gas)
4. Arwen shotgun (rubber bullets or plastic popsicle sticks)
5. Fifteen-foot white metal extendable prong
6. Pepper ball rounds (O. C. spray)
7. Stunned or flash grenades
8. Percussion grenade
9. Taser (electrical stimuli into large muscle groups)

We had a fascinating presentation from the Senior Vice President of Metal Storm, Inc. of Arlington, Virginia, U.S.A. This Company certainly appears to be on the cutting edge of the technology of variable lethality small arms. These multi-barreled weapons can "electronically select fire from a number of different ammunition types and lethalities to match the level of any threat."

Many of the above intermediate weapons are used by special squads, like a Tactics and Rescue Unit (TRU) or an ERT (Emergency Response Team). In the R.C.M.P. organization, every Division has an ERT which also regularly uses the services of crisis negotiators, specially trained dogs, sharpshooters, etc. The reality is that it takes time to mobilize (around one hour) and time to travel (ex. about five hours to Botwood). Even with a dedicated aircraft on standby and ideal weather conditions, it would have taken a minimum three to four hours for the ERT to arrive in Little Catalina.

It is not reasonable to expect more of the R.C.M.P. in this way. Nor is it reasonable to expect each Detachment to have available these types of personnel and equipment. Generally, these weapons are not for frontline officers.

What should be expected of a modern, professional force would be the availability of Tasers on a local level. Assistant Commissioner Lawrence Warren advised us that since November 2001, the R.C.M.P. in Newfoundland and Labrador has acquired sixty Tasers at a cost of $124,000, including training which is taking place. Assistant Commissioner Warren further reassured the Inquiry that the R.C.M.P. is constantly reviewing what is available. No recommendation is needed in this subject area.

Strictly as an aside, the R.C.M.P. is not alone in the acquisition of Tasers. The following information was not before the Inquiry but reference to the website, www.taser.com, reveals substantial orders from many police forces. Furthermore, investors have recognized the value of the company which has seen its stock price sore more than 2500 percent in the last year (tasr: nasdaq).

If we as a society are not able to do any better for people like Norman Reid as far as social and health services, there is little point in pursuing alternative weapons, which admittedly would prevent some deaths but would result in more wounded people and probably more serious incidents.

Tasers are not one hundred percent effective. There are situations where thick clothing or other factors may prevent them from achieving their purpose.

Again, this evidence was not before the Inquiry, but there was a tragic incident in Vancouver within the last three months or so where a thirty-six-year-old male was shot to death by a City police officer.

The subject had never been assessed although he had a history of mental illness. According to the *Globe and Mail*: "City police shot a man coming toward two officers with a knife Saturday night after a Taser stun gun had no effect on him, spokeswoman Constable Anne Drennan said yesterday. Police responded to a call Saturday evening from family members of a man with a history of mental illness. When the two officers and a mental-health-care team arrived, the man, 36, was armed with a knife and started coming toward police, ignoring commands to drop the weapon, she said. "When he got dangerously close to the officers, one of the [officers] fired one shot into his chest and killed him," Constable Drennan said."

8. Conclusion

On a beautiful Saturday afternoon in late summer 2000, when many Newfoundlanders and Labradorians were occupied with the food fishery and other seasonal pursuits, a forty-three-year-old male resident of Little Catalina, Norman Edward Reid, spoke serious threats of horrific violence concerning children to a young man of the same community. This young man, in great fear, phoned the R.C.M.P. who responded to the area with three officers in two vehicles.

Norman Edward Reid had been consistently diagnosed with paranoid schizophrenia for more than twenty years. This condition worsened drastically and he became increasingly dangerous.

Upon approaching the Reid property, the three police officers were quickly confronted by Norman Edward Reid in a highly disturbed and agitated state. Mr. Reid was holding a small axe in a threatening manner. The officers drew their service pistols in an effort to persuade Mr. Reid to drop the axe and to contain him on his bridge.

The standoff lasted approximately twelve minutes. Suddenly, Mr. Reid quickly departed the bridge and the steps, heading toward Constable Graham, threatening to kill the officer. Constable Graham stopped the threat with five bullets.

Pronounced dead at the Bonavista Hospital, Norman Edward Reid actually died in his back garden at Little Catalina in the Province of Newfoundland and Labrador at approximately 4:06 pm on August 26, 2000. The cause of death was "exsanguination (blood loss) due to multiple gun shot wounds of the torso and extremities."

The manner of death was homicide.

PART 2 - DARRYL POWER

9. Factual Review

9.1 Darryl Power

a. Family, Education and Health Care

Darryl Brandon Power was born in Mississauga, Ontario on July 23, 1977, and died tragically on October 16, 2000, at Corner Brook, Newfoundland and Labrador.[36] He was the youngest of three children born to Catherine and Cyril Power.

Darryl Power's childhood and adolescent years were spent in the Province of Ontario with the exception of two moves "back home", both of which were brief.

As early as the age of nine or ten, Mrs. Power felt there was something wrong with her son, Darryl, as he was often sick and felt very uncomfortable in crowds. It appears that he may have developed ulcers perhaps when he was as young as eight.

According to the evidence of his mother, there was not one major single traumatic event such as sexual or physical abuse which would have caused this change. Rather, many years of family strife including alcohol dependency and anxiety problems of the father, marital discord, financial pressures, etc. wreaked havoc on this young, sensitive boy.

In the submission of the C.M.H.A., the family life was described as follows:

"Darryl Power was raised in a complex family environment. His parents required a high level of support in relation to their own addiction and abuse issues. Early in his life, Darryl developed, was diagnosed and treated as having an anxiety disorder. Mr. and Mrs.

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[36] Catherine Power told the Inquiry, her son was christened Darrell Brandon Power. He spelled his name "D A R R Y L." Throughout the report I will use "Darryl".

Power did not have the requisite knowledge or skills necessary to support their son effectively. His parents struggled to support him, and provide him with assistance. The Power's own issues often became overwhelming for them and they were not able to provide Darryl with the support he needed."[37]

In fact, hospital records are replete with numerous instances of the chaotic and troubling family life.

Dr. B. Furlong is a psychiatrist the parents respected and whose services were sought out. In his May 1993 report about Darryl Power's admission to the York County Hospital in Newmarket, Ontario, from November 30, 1992 to December 23, 1992, Dr. Furlong wrote as follows:

> "Darryl is a 15 year old adolescent who had been living at home in Bradford with both parents. He was seen in the ER on November 30th, 1992, along with his father. He presented with a two week history of acute panic attacks which were increasing in frequency and severity. The onset of the acute panic appeared to coincide with the break-up of the family unit three weeks ago, at which point his mother and Darryl moved out from the family home because his father had been drinking and was emotionally abusive. One week later his mother returned home following promises that Darryl's father would discontinue his drinking, however, Darryl decided to stay behind in the small basement apartment. Following this he became much more anxious, had difficulty sleeping, trouble coping, and became obsessed with his health. Background history indicates that he has no friends or hobbies and had at this point been away from school for two and a half years because he could not function in the classroom secondary to his anxiety.
>
> Darryl had no significant past medical history apart from a pencil lead injury to the left leg approximately five years ago. He has no previous psychiatric history and has no known history of alcohol or street drug involvement.
>
> A family meeting was conducted which indicated longstanding chaos in this family secondary to the father's alcoholism and chronic marital dysfunction.

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[37] Sandra Burke, Inquiry Brief, at 11.

> It became apparent that Darryl is the youngest of three kids who have grown up in a very dysfunctional family, characterized by alcoholism, chronic parental marital dysfunction, unpredictability, and poor emotional support, leaving him essentially a frightened, apprehensive boy. Clinically, he presented as anxious with very definite panic attacks which appeared to be intensified by dealing with any stressful issue. During his stay in hospital, he fluctuated between articulating that he could not return home because of the ongoing tension with his parents, clearly had very significant difficulties in making any definitive decision around this, although considerable time was spent with him in examining available options. In the end, he left hospital AMA on December 23rd saying that he had decided to make a go of it at home, but one also had the impression that his impatience got in the way of him wanting to see the process through to completion regarding ultimate living arrangements.
>
> At the point of his leaving hospital, he was on no medication."

In 1993, following a three month stay at York County Hospital and a return home, Darryl Power spent a few months at the Robert Thompson Youth and Family Centre, and was discharged on December 17th of that year. A reading of the Residential Case Conference Report of December 15th reveals the following:

1) improved behaviour with parents on home visits;
2) more subtle acting out behaviours with staff;
3) feelings of "confusion, frustration and being over-whelmed";
4) difficulty with staff authority;
5) ongoing concern with "parents' constant fighting";
6) active participation in group therapy;
7) missing scheduled appointments;
8) consistently good participation in leisure education programme;
9) defensive when confronted about unacceptable behaviour;
10) struggled with free time;
11) difficulty identifying and coping with his feelings;
12) anticipation of problems when returning to regular school.

Darryl Power had the benefit of intensive supervision and guidance at this highly developed residential programme and yet, within less than two years including a group home placement for five weeks, Darryl Power's mental health problems, particularly anxiety and depression, had escalated.

In an October 1995 report, L. Bryan, Social Worker of York County Hospital, wrote:

> "While he was initially receptive, he became quite obstructive and negative when suggestions for assistance and dealing with his anxiety and referrals were provided and said that he "knew all about" these physicians, agencies, techniques, etc. and that they were "no good" ... He refuses an appointment with a psychiatrist for medication review to consider an anxiety disorder program or consider any options other than resting."

Dr. Bourne admitted Darryl Power to the hospital for "acute anxiety" noting the "history of alcohol abuse by his Dad" and the "strong history of family dysfunction". At this time, there was no suicidal ideation nor acute depression.

Psychologist, A. J. Kizik in a November 1995, report stated:

> "On the MMPI, Darryl obtained moderately high elevations in scales relating to hysteria, psychopathology and depression. This would indicate a combination of rebelliousness, high anxiety and lack of insight. Most of his difficulties stem from deep chronic feelings of hostility toward parental figures. He is very sensitive to rejection and feels hostile when criticized. His high level of anxiety likely manifests itself in somatic symptoms and this causes him to complain of weakness and easy fatigability.
>
> It is very difficult for Darryl to express his aggressive feelings in an appropriate manner. He is subject to acting out behaviour and this may be followed by periods of remorse."

In a nurse's note the following month, Linda Tupper, R. N., related the following:

> "... Darryl was feeling somewhat depressed and suicidal ... had visited with his parents today and the father came home drunk. Darryl had a difficult time with this, became angry at his father, got into an argument, and then left and went to his group home, whereby he began feeling suicidal and thought he needed to come to hospital."

Just four months later, Dr. Palermo saw Darryl Power when he was admitted having been brought to the hospital by ambulance. Police had been called. Darryl Power recounted to Dr. Palermo that he had an altercation with his father, an inpatient on the psychiatric floor of York County Hospital who had been discharged on a day pass. Darryl Power told Dr. Palermo that he did not want to live anymore.

In two reports by psychiatrist, P. Zelina, in October and November of 1995, the themes of family dysfunction and anxiety continue. Of some concern was his appearing to be "very manipulative". Also "the father sent him to a group home where he is currently with some older people with a history of major mental illness". The family crisis was described as "current and chronic".

Attendance at public schools was a major issue with Darryl Power who sometimes missed 100 days a year. Dropping out of school in Grade X, in Central Ontario, he briefly attended school in Ottawa where he lived at the Y.M.C.A. By this time, his parents had left Ontario for their final return to Newfoundland.

Unable to live independently, especially after a close friend's suicide in Ottawa, Darryl Power returned to Newfoundland in 1997, to be with his mother. Cyril Power continued to suffer from anxiety problems and may have been hospitalized for a few weeks.

While at home with his mother, Darryl Power read books including self-help and the Bible and listened to music. He particularly enjoyed the gospel music of Elvis Presley. His times of being thoughtful and caring at home however, were interspersed with long periods of up to two weeks in bed, only getting up to go to the bathroom.

Darryl Power's first experience at Western Memorial Regional Hospital was in September 1997. He was twenty years old, with considerable experience in the mental health system of Ontario. The psychiatrist was Dr. Okyere. His summary includes the following:

> "Informal Admission following overdoes 6 x 20mgs. of Paxil tablets, 10 of 1mgs. Ativan tablets, 2 Sleep-eze (Dinemhydrinate tablets) and about 4 tablets Aspirin the previous evening. He recounted having felt that as a religious person it was wrong to know that his father had stolen a quantity of copper from a company and not informed the law enforcement agencies about it. He had called the police that previous night and informed them about the theft and then felt that this was going to be big trouble with his father. He tried to slash his wrist so he could get hold of a vein or some vital structure that he would destroy and end his life but found the pain unbearable when he cut himself. He then took the tablets but his mother found him to be drowsy when he went to ask her for money to buy beer and arranged to bring him into the hospital. ... At the time, he recounted, that his father had been abusing his mother for a prolonged period following which he and his mother moved into a motel and then into a home. He was upset that his mother wanted to go back. He had arguments with her but she moved back with his father leaving him in the house for two weeks prior to his waking [sic] to his father's place of work on the fateful morning."[38]

In October and November 1997, Darryl Power found himself in Ottawa again. He told the psychiatrist, Dr. L. Varan, "I have a mental illness, a personality disorder and problems with anger". Dr. Varan noted the following:

- "20 yr. old male with substance abuse and mood problems since his teens";
- "on Lorazepam and Paroxetine X two years";
- "family discord";

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[38] George Murphy, Inquiry Brief, Vol. 1, at 18.

- "physical conflict with his father";

- "physically aggressive ... kicking and breaking a door in anger";

- "mood is "depressed, angry and destructive" for the previous few years, though it has been worse since his last discharge";

- "physical abuse from his father but no sexual abuse";

- "in his childhood ... good grades and got along with other students and teachers";

- "unsupportive family ... father ... retired carpet installer and truck driver, who is an alcoholic, who physically abused the patient as well as his mother";

- "seemed to externalize and blame all of his problems on others, not taking responsibility for himself ... denied that substance abuse was a problem ... often became mad when confronted with things"; and

- "discharge against medical advice".

As we move ahead, the same matters continue to present themselves with increasing severity, and there is more frequent reference to suicide and drug overdoses. There are at a minimum eleven appearances at the Ottawa General Hospital with four or five admissions.

In February of 1998, Darryl Power talked of two suicide plans, one of which included attacking a police officer with a toy gun. A few months later, in May, he called police in Ottawa, telling them he had a gun and wanted to kill himself.

Hospital records reveal that Darryl Power returned to Newfoundland in late autumn,1998. From then, until his death two years later, he had no fewer than nine admissions to Western Memorial Regional Hospital and at least two dozen visits to his family physician, Dr. Ogbuah, plus a brief stay at the Waterford Hospital in St. John's, in February of 2000.

The same problems and issues were present throughout his last two years: family dysfunction, depression, substance abuse, mood wings, suicide ideation, manipulation, missed appointments, anger, despair and frustration - a pitiful existence. I do not want to paint too bleak a picture here so I will spare many of the details, highlighting relatively few:

1) five of the last six admissions to W.M.R.H., he self-discharged;
2) missed key appointments with the psychologist and occupational therapist;
3) in May, 1999, despite considerable effort and expense allowing him to go into St. John's to see a psychiatrist, he slept in and then refused to go;
4) frequent written reference to suicide; and
5) interactions with R.N.C.

Items four and five will be addressed in some detail in following sections.

It did seem that Darryl Power established a good rapport with Dr. Ogbuah having seen him about twenty-five times. Dr. Ogbuah was very patient and understanding of his patient. However, even he became upset when Darryl Power missed the initial appointment with Dr. Nurse, a psychiatrist in St. John's, and later refused to attend at all. Dr. Ogbuah had gone the extra mile many times for Darryl Power, but to no avail.

In September 1999, Dr. Ogbuah wrote the parents about the missed appointments at the rehabilitation centre:

> "Please be advised that if Darryl does not wish to take advantage of all the help being offered to him, he should say so and stop wasting people's time."

Dr. Ogbuah felt that Darryl Power needed to live in a transition house with a professional staffing model, and that discharges from W.M.R.H. to live with his parents was a problematic situation. While Dr. Ogbuah would have favoured Darryl Power staying at a transition house on a voluntary basis, it is my view that this would not have lasted largely due to Darryl's mood swings, reluctance to accept authority, manipulative tendencies, etc.

The last contact Darryl Power had with Dr. Ogbuah was on October 10, 2000, just six days before his death. Again, as was ususal, Dr. Ogbuah did not hesitate to spend time with his patient, counselling and encouraging him. Darryl Power told him that he was feeling better and was going back to Ontario to work, denying once again to Dr. Ogbuah any suicide ideation.

b. Personal Writings

Exhibits CS #3 and CS #4, contain the personal writings of Darryl Power which were taken from his apartment at 16 Callahan's Road and his mother's apartment at 21B Westmount Road. While it is acknowledged that the writing of personal thoughts is an important part of therapy and is also indicative of loneliness, despair, and a cry for help, it is my view that the constant deep and graphic references to death are also very much consistent with a desire to die.

These writings contain reference to schooling, Toronto Blue Jays, Toronto Maple Leafs, Russian politics, the environment, physical exercise, diet, the sacred songs of Elvis Presley, the Bible, etc. The subject of suicide is however, prevalent and I shall set out various writings most of which, as best I can tell, are from the last four months of his life:

> "... today is my twenty-third birthday ... sometimes I want to give up and let go of everything including my life ..."
>
> "... suicide ... cause of death ... alcohol and drug poisoning ... require alcohol-a-plenty ... sleeping pills"

"thinking about taking my life is a frequent thought many times a day"

"suicide was on my mind for a long time and now it's time to get it over with ... every way to kill myself has crossed my mind. Now I have to choose one way and go through with it"

"... suicide is my only option ... this has to end quickly and I mean now ... last meal - pork chops and spicy fries, then it's over ... no matter what, I will find a way"

"no people are on my side"

"continuation of my life is based on morals that I am getting close to abandoning"

"the people can go on in this disgusting world without me"

"an emergency call is forwarded to the police.

"Stand back, I've got a weapon". Find a real gun? Where? Someone in Canada doesn't just hand you a gun!"

September 12, 2000
"I know that soon all my sorrows will be over. October will be my last month living on earth. I cannot co-exist with the living devil here on earth. My place is in death. Then I will be free of everything ... I can't wait to get away from every one these people."

October 2, 2000, Current update:
"My life situation has drastically worsened, this is a crisis situation. I am losing self-control:

1. No familly support at all.

2. Bad living conditions. With mother in problems (am alone and unable to care for myself. Loud people above me).

3. No work.

4. Court date on October 13th, 2000 (charged with assault causing bodily harm)

> 5. Dependent on medications.
>
> 6. Depression and anxiety worsening (very suicidal) and anger is reaching an all time high - induced by all of the current stressful situations.
>
> 7. Social disorder of the Schizoid type - (poor relations with people).
>
> 8. Poor resources in NFLD. Trying to get in a school program for adults but am unable because of a v-long waiting list.
>
> 9. General dislike for society.
>
> NOTE I am confused with any solutions to these various problems. * This is a problem that has intensified over the past few years as I've become an adult an had to depend on myself more and more. It seems people don't want to offer help to those who get older and older in time. I am becomming less and less able to attend to my everyday needs. Life has gotten worse and worse for me."
>
> October XX, 2000)
> "This will be the day of my death. Just fill in the blanks. I feel it coming very soon. Not just my death, but the death of the world. I can't waite this long. What am I waiting for? I need a plan(e) and fast. ... poison myself with a combo of house cleaning products ... Trans Canada Highway and jump in front of a fast moving tractor and trailer."

An apparent suicide letter addressed to Loretta (sister), David (brother), Mom, Dad, Julie and Brian was never delivered:

> "I regret to hurt anyone. I just can't go on. Please understand that maybe this is wrong but I've spent years thinking about it. Ultimately this is my final choice ..."

It has been submitted to the Inquiry that because Darryl Power had plans for the future in October 2000, that he was not suicidal. This position is not accepted. Most of his plans were totally unrealistic and unattainable. There was no way whatsoever that Darryl

Power was going to save $5,000 secretly, learn to invest money, become a fitness instructor, rehabilitate others, work in Red Deer, Alberta or Ontario. Short of divine intervention, Darryl Power was just simply not in a position to have reversed the irreparable harm that was forced on him in his childhood. Deep down, Darryl Power realized that he was never going to be independent. Close examination of his personal writings clearly reveals that he was overwhelmed by his lack of prospects.

In his writings there were very few realistic goals for the future. Some of these included losing weight, exercising more, attending basic education at a grade nine level, reconnecting with Jehovah's Witnesses and reading more.

Unfortunately, towards the end, the periods of severe depression and hopelessness were increasingly prolonged in depth and time and the moments of peace, contentment and the desire to improve his sad lot in life were decreasing in scope and reality.

I agree with the submission of Western Health Care Corporation.

> "Given that one has to assume that no person in these situations would rationally decide to spurn help when help is clearly indicated and available, one can only conclude that Darryl Power's attitude towards his caregivers and his reluctance to participate in treatment programs were themselves part and parcel of his underlying condition, perhaps even symptomatic thereof. If that be the case, then no one should be surprised how difficult it is for professionals to treat and manage patients suffering from Darryl Power's type of mental illness. (Indeed, Dr. Ladha, who preferred to think of Borderline Personality Disorder as an affective disorder, pointed out how very difficult it is to treat persons labouring with this condition). Further, and regrettably, cases such as Darryl Power's suggest that even he availability of suitable hospital and community-based resources may not prevent the saddest of outcomes in all cases."[39]

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[39] Paul McDonald, Inquiry Brief, at 18.

c. Contacts with Western Memorial Regional Hospital

i. Nursing Perspective

Helen Mercer, a psychiatric nurse at W.M.R.H. with 30 years experience at the Waterford Hospital, Grace Hospital, Roddick Hospital (Stephenville) and Corner Brook, reviewed the files of Darryl Power's ten contacts at W.M.R.H.

The first stay in the late summer of 1997, was brought about by an overdose, with suicidal thoughts, after a family conflict. His behaviour was characterized as "demanding, irritable, angry, using foul language against staff".

The second and third stays were in November and December of 1998. There were moments noted of lessons learned, being pleasant and wanting help; but, the consistent themes of anger, aggression, suicide, overdoses, ceasing to take medications and family dysfunction, surfaced again.

Stays four through eight occurred in 1999. Recurring themes of depression, suicide, angry outbursts, alcohol abuse, missed appointments, unacceptance of authority and family problems were generally present.

On the fifth stay, there was a note of paranoid thoughts - government conspiracy and that if he had a gun he'd hurt somebody when he was mad. On the eighth stay, Darryl Power, again spouting bizarre thoughts of the police and the government, stated that if he would hurt someone it would be a police officer.

The ninth stay occurred on February 4, 2000, from 1:30am until 6am. Depression and a suicide attempt by overdose caused Dr. Dean to admit him. Darryl Power made a contract with witness, Helen Mercer, that he would not harm himself after earlier vowing that the next time he would succeed at suicide.

The final stay from September 24-25, 2000, within three weeks of his death, was also very brief. His early departure from the unit represented his sixth self discharge out of ten admissions.

There was a note for the first time about squandering of his very limited financial resources through gambling, take-out food and taxis. Darryl Power, angry at a student, living above his mother's apartment for being somewhat noisy at night, "if I had a gun, it would be easy to pull the trigger". Dr. O'Connor had admitted him because she felt he had both suicidal and homicidal ideations. Dr. Nazeer, the psychiatrist, disagreed.

Helen Mercer told us in some detail about the team approach to treating patients at W.M.R.H. Local terminology is "case rounds" as opposed to "case management team". She recognized that there was no outpatient team for outpatients and not a lot of follow-up in the community, most especially for patients like Darryl Power who were reluctant to pursue these avenues.

ii. Occupational Therapy Perspective

Jennifer Wyeth gave us useful information in this subject area. In her department, they focus on daily activities - physical, mental, cognitive and spiritual aspects of everyday living.

A summary of Darryl Power's involvement, and lack thereof, with occupational therapy is summarized in the W.M.R.H. submission.

> "Darryl was interviewed by Occupational Therapy at the Hospital on September 10, 1997, with a followup appointment scheduled for September 15, 1997. Darryl had by then, however, discharged himself against medical advice, and this followup appointment did not take place.
>
> However, and also through the services of the Occupational Therapy Department, Darryl Power was referred to the West Lane recycling program in September 1999, and attended an intake interview in early November 1999. Darryl did show up for two days of the six day on-site assessment at West Lane, but then didn't show up thereafter. The Occupational Therapist called and spoke with Darryl's mother, who advised that Darryl was then at home, and very anxious. Darryl was written and told that the West Lane program would hold the next available placement for him, and he was asked to call West Lane when he felt better. Nothing further was heard from Darryl however, and after waiting three months, West Lane discharged Darryl from its placement list. Darryl was again referred (to his knowledge) to the West Lane recycling program on September 21, 2000, but he was dead before another attempt could be made to enroll him in the program."[40]

iii. Rehabilitation Perspective

The Regional Director of Rehabilitative Services at Western Health Care Corporation, Julie Kingston, reviewed the files and highlighted for us her division's involvement with Darryl Power.

Normally, a social worker is a member of the inter-disciplinary team; however, because half of the stays were so short, there was no reference to a social worker for admissions 1, 2, 5, 9 and 10.

A major problem throughout the significant efforts of rehabilitation services was that Darryl Power failed to follow through and show up for appointments. Reference has already been made to Dr. Ogbuah's great disappointment about Darryl Power having initially slept in and then refusing to see Dr. Nurse in St. John's. Pat Stratton, with financial and administrative responsibilities at W.M.R.H., had made a considerable effort at the request of Dr. Ogbuah to provide expense money for all the travel arrangements for the trip to and from St. John's.

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[40] Paul McDonald, Inquiry Brief, at 11.

Also, this department co-ordinated arrangements for the following:

1) follow-up with social worker, Renee Fowler, January 5, 1999,
2) referral for intake at Humberwood (residential treatment for substance abuse), March 23, 2000, and
3) referral to Adult Mental Health for longer term psychotherapy and counselling, March 27, 2000.

All of these initiatives failed because Darryl Power failed to show up.

While acknowledging that there were not enough staff, which caused long waiting lists, Julie Kingston did advise that there were more community resources then an outsider would realize. These include the following:

- crisis line;
- family and friends;
- 911;
- emergency department;
- on call psychiatrist liaison with Blomidon Place;
- addiction services;
- adult mental health;
- support groups - C.H.A.N.N.A.L.;
  - Blomidon drop-in; and
- Xavier House

These types of community services have grown, especially in the last five years or so. A similar listing was provided by Donna Luther, Assistant Director of Nursing.

Due to an extraordinary turnover of psychiatrists in Corner Brook in recent years, there were times that this region was terribly understaffed. In May 1999, an appointment was set up for Darryl Power to see a psychiatrist in St. John's. In the year 2000, there were two psychiatrists at W.M.R.H. and one in Stephenville. This region should have a complement of six.

iv. Psychiatric Perspective

Dr. M. R. Sayeed obtained his M.D. in Pakistan and trained as a psychiatrist in Virginia, U.S.A. He, himself, had no dealings with Darryl Power but helped the Inquiry interpret the charts.

It appears that on his ten admissions to W.M.R.H. Darryl Power saw no fewer than six psychiatrists, none of them more than once.

The themes addressed in the previous perspectives were present here as well, family dysfunction, depression, overdose, suicide, manipulation, substance abuse, etc.

The various diagnoses started with panic disorder with agoraphobia, major depressive disorder, borderline personality disorder and adjustment disorder with anxiety and impulsivity. Dr. Sayeed, in reviewing the files, concluded that essentially the diagnosis was that of Borderline Personality Disorder.

Dr. Sayeed explained about the four categories of suicide ideation:

1) gestures (pseudo suicide)
   - no intention to complete the act

2) parasuicide
   - moment of passion to get attention
   - soon regretted
   - if actually committed, a mistake

3) acute

- generally an older person who plans, makes a will, gives away possessions and then executes the plan

4) chronic
   - fluctuates between having and not having suicidal thoughts

Dr. Sayeed's opinion was that Darryl Power was definitely not in the third category, but rather in the fourth or second.

v. Psychological Perspective

Ross Loomes has been a registered, licenced psychologist since 1981 and has been employed at W.M.R.H. since 1994. In September 1997, Darryl Power was referred to Mr. Loomes. He did not show up. His family doctor and a nurse referred him again in March 1999. This time Darryl Power saw the psychologist on March 16th, as an inpatient. Ross Loomes noted that Darryl Power was polite, very mannerly, but distant. He wanted to break down the barriers with his client and get close to him. The issues mentioned in previous perspectives were brought to light.

Darryl Power failed to show for the next appointment on March 29, 1999. Mr. Loomes saw him again as an inpatient on October 4, 1999, and a final time on October 13, 1999, which was the only time Darryl Power saw him as an outpatient. Mr. Loomes felt at this time that Darryl was not suicidal because of his desire to upgrade his education. He also wanted to obtain a driver's licence. Ross Loomes felt that the October 4th interview was the most Darryl Power had ever opened up to anyone, as he recounted the abuse that he and his siblings and his mother suffered at the hands of his father. Mr. Loomes told Darryl Power that his father was responsible for his problems. Clearly, Darryl Power felt both anger and guilt as do so many others from abusive home situations. I agree with Mr. Loomes' observation that Darryl Power was overwhelmed by his anguish and feelings.

There was a serious miscommunication on October 5, 2000. That day, Mrs. Power came to his office door unannounced concerned about a suicide note her son had written. Mr. Loomes spent about forty minutes with her - she was very upset. Darryl Power was not with them. There was some disagreement as to how Darryl Power should be admitted - whether it was the psychiatrist's duty or that of the family physician. This difficulty was unfortunate, but fortunately not tragic. Darryl Power was not admitted but did have a positive session with Dr. Ogbuah on October 10th, five days after the proposed admission and six days before his death. The bureaucratic difficulties preventing his admission that day ought not to have occurred. I leave it to the administration of the W.M.R.H. to address this type of regrettable situation.

Furthermore, it was Ross Loomes' position, that in the end, he couldn't have done anything for Darryl who had great difficulty with rules and authority and was up and down all the time.

Although he did not make a note of it, Ross Loomes recalls Darryl Power making a comment in the previous year to the effect that a good way to die would be to get a police officer to shoot you. Mr. Loomes classified this remark as a comment and not a plan.

It was Ross Loomes' conclusion that Darryl Power's death was "suicide by cop".

d. Social Assistance

Tom Power, district manager with the Department of Human Resources and Employment spoke of the various programmes that were available to Darryl Power.

Darryl Power had returned to Corner Brook from Ontario in November 1998, and, in the following month was put into a higher category of income support because he was unable to work. For the full duration of the file, Darryl Power had a drug card. Mr. Power told us of the flexibility that was available in terms of recreation, training allowances, and one month increase in his assistance despite living with a relative, i.e. his mother.

It appears that he rented an apartment on Callahan's Road in October of 1999. The Department provided the rent of $260 plus a living allowance of $401, plus the drug card, travel, etc. per month. Darryl Power remained at this level of financial assistance until his death in October 2000.

e. The Crisis Line

Karen Moores, Manager of Mental Health Services with the St. John's Regional Health and Community Services Board, told us of the work of the Mental Health Crisis Centre, located on St. Clare Ave. in St. John's, in particular, the crisis telephone line service. The Centre, established in 1996, is open everyday around the clock. It is well-publicized with a toll free number (1-888-737-4668). Operating on a professional staffing model, the staff consists of registered nurses, licensed practical nurses, registered social workers and volunteers. The Centre ensures that two professional staff members are always on duty.

In the fall of 2000, the Centre received approximately 450 calls per month, almost 90% of a crisis nature dealing with issues such as suicide, relationships, financial stresses, and other mental health concerns.

The phone system is designed so that the caller will speak to a staff member as opposed to a message manager. In 1995-96, the Steering Committee accepted the recommendation of the consumers not to have the calls taped, nor is a caller required to identify himself/herself. If there is some real concern about immediate danger, the staff will establish contact with either the R.N.C. or R.C.M.P., provided of course that the identity is known.

Details of Darryl Power's calls are set out as follows:

> "The Crisis Centre has 11 Call Records for Darryl Power or his family prior to 16 October 2000. The records commence on 10 December 1998 and conclude on 12 April 2000. The data bank information available to Karen Moores disclosed the length of seven (7) calls, namely, 45 minutes (30 December 1998, actually 35 minutes), 105 minutes (7 March 1999), 10 minutes (23 March 1999), 10 minutes (10 April 1999), 20 minutes (4 February 2000), 15 minutes (11 April 2000), and 60 minutes (12 April 2000). Thus, the calls ranged in length from 10 minutes to 105 minutes, with three (3) of the calls being 45, 60, and 105 minutes. Where suicidal ideation was identified in one (1) call from the family, 12 December 1998, the staff encouraged contact with the R.N.C. and staff also called the R.N.C. in Corner Brook. Not all calls referenced suicide and no call was made to the police where staff considered that there was no imminent danger or appropriate intervention was under way, e.g., 4 February 2000. Where appropriate, staff arranged a no-harm "contract" with Darryl Power, e.g., 12 April 2000. In one case, involving two (2) separate back-to-back calls, 23 March 1999, staff contacted the R.N.C. where there was concern for Darryl Power's mother's safety. Also, staff terminated both calls where Darryl Power was abusive to the staff member.
>
> The Crisis Centre has no record, by way of logging or data entry, of a call coming from Darryl Power in the early morning of 16 October 2000. Nor is

> there a log for an anonymous call at that time. Upon being made aware on 30 August 2002 of testimony from Darryl Power's mother of such a call, Karen Moores checked with Aliant Telecom and was provided with a call record showing a call from the Powers' telephone number to the Crisis Centre at 4:46 a.m. on 16 October 2000. The call was recorded to have lasted 5 minutes and 8 seconds. On the relevant shift, namely, 8:00 p.m. to 8:00 a.m., 15-16 October, there is a record of three (3) telephone calls and two (2) walk-in clients. Two (2) of the calls occurred before midnight on 15 October 2000 and the third call was at 5:30 a.m. on 16 October 2000. Both walk-ins occurred at the start of the shift. Ms. Moores surmised in her testimony that it was a very quiet night.[41]

The Inquiry finds that the telephone call was made by Darryl Power on October 16th at 4:46 am to the Crisis Line. What unfortunately remains a mystery is why there is no record nor recollection of this call. The Inquiry is unable to conclude whether or not the call was adequately handled; although past experiences, properly documented, reveal a pattern of appropriate intervention.

It is possible that, despite the call being made in the last hour of his life, that it wasn't a crisis call. Darryl Power had told his mother that the person taking the call was "nicer than the one the other night". Also this call was the shortest on record, five minutes, compared with others ranging from ten minutes to one hundred and five minutes. Nonetheless, it would have been helpful to know more about this particular telephone call.

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[41] Augustus G. Lilly, Q.C., Inquiry Brief, at 4.

The Board has, effective October 10, 2002, taken the necessary steps to ensure that:

> 1. All visits and calls must be logged showing date, time and purpose and using the 24-hour clock when recording time. The log must indicate when a call or visit does not require intervention.
>
> 2. A client record must be created for any client intervention.
>
> 3. All client records must be recorded electronically within 24 hours, with staff to notify the Manager when this is not possible.
>
> 4. Staff who identify a problem with the electronic data system must notify Information Systems.[42]

These measures, plus the filling of the position of Manager of Mental Health Services at the Centre, satisfactorily address the problem identified at the Inquiry.

f. R.N.C. Contacts with Darryl Power and the Family

There were twenty-eight files generated by the R.N.C. concerning Darryl Power and his parents, Catherine and Cyril Power.

They have been summarized for counsel by Constable Earles as follows:

> "There are many incident files at R.N.C. headquarters related to Darryl Power or his family. The earliest relates to a call placed by Mrs. Power to Western Memorial Regional Hospital reporting that her son had taken an overdose (**File #97-3671**) on September 3, 1997.
>
> **File 97-3775** relates to an allegation against Mr. Power that he had pushed another patient through the wall at the Western Memorial Regional Hospital psychiatric unit on September 10, 1997. No charges were laid.

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[42] *Ibid.* at 7-8.

File 97-3841 related to charges laid against Mr. Power for threatening a staff member at the hospital and damaging some property. Following this an entry was entered on CPIC stating "caution-violence".

File 98-4927 related to a call from Mr. Cyril Power reporting that Darryl had taken an overdose on November 23, 1998.

File 98-4957 relates to an arrest of Darryl Power under warrant in relation to an assault and causing a disturbance in early January 1998.

File 98-5159 related to another call stating that Darryl had taken an overdose on December 10, 1998 and he was being aggressive.

File 98-5317 referred to a call from Catherine Power to discuss her options regarding her abusive husband. This call occurred on December 20, 1998.

File 98-5336 relates to a complaint filed by Catherine Power that her husband Mr. Cyril Power had assaulted her approximately November 20, 1998. In this complaint Mrs. Power outlined the 35 year history of abuse at the hands of her husband. This matter was ultimately dealt with by way of peace bond as Mrs. Power did not wish any charges to be laid once her husband moved out.

File 99-0396 relates to an allegation by Catherine Power that Mr. Cyril Power had threatened her.

File 99-0839 related to another overdose taken by Darryl on March 9, 1999 and that Darryl was refusing to go with the ambulance.

File 99-0860 relates to a call placed by Mr. Cyril Power to the R.N.C. complaining that somebody was knocking on his door. This call was placed on March 10, 1999.

File 99-1023 related to a call from Darryl to the police stating that his mother had left the home and was acting unusual. This call was placed on March 22, 1999.

File 99-1181 related to a call placed by Catherine Power on April 3, 1999 requesting that Darryl be removed from her residence because he had been threatening her and she was afraid to go back home.

File 99-1261 related to a call from Darryl on April 10, 1999 seeking assistance for himself stating that he was going to harm himself.

File 99-1928 relates to a call received from Western Memorial Regional Hospital on May 24, 1999 stating that Darryl had been certified by Dr. Sparrow under the Mental Health Act but he had left the hospital. Darryl was detained and returned to the hospital.

File 99-2570 related to a call from Darryl on July 3, 1999 seeking help for a person named Mary Gale who was "very suicidal".

File 99-4216 relates to a matter where Darryl was removed from West Side Charlie's and was reported to be outside the club trying to start a fight. This was on October 26, 1999. When responding officers Constable Roche and Constable Haskell arrived Darryl was upset and crying. Darryl was aggressive towards police and challenged Constable Roche and Constable Haskell to hit him. The officers decided to detain Mr. Power under the Detention of Intoxicated Persons Act. Mr. Power resisted arrest, was placed in hand cuffs, and while in the police vehicle began to bang his head off the door. The file references that Darryl stated that the police were going to "beat the shit out of him". When he began to talk about suicide the officers then decided to detain him under the Mental Health Act.

File 99-4643 relates to a call placed on November 28, 1999 regarding a disturbance at 21B Westmount Road. Mr. Cyril Power and Mrs. Catherine Power had gotten into an argument. Even though Mr. Power was under a bond he was at the residence by consent of Mrs. Power. Mr. Power was removed and brought to his mother's residence.

File 99-4650 relates to a complaint filed by Catherine Power against her husband on November 28, 1999 that he had forced his way into her home. Constable Earles was one of the responding officers. Charges were laid against Mr. Power for damage to property and breach of bond. He pleaded guilty to these charges and was given a suspended sentence and placed on twelve months probation.

File 99-4658 related to prisoner escort for Mr. Cyril Power who was in custody on November 29, 1999.

File 00-0457 relates to a call placed by Catherine Power on February 3, 2000 stating that her son was sick and suicidal and needed to go to the Hospital.

File 00-0468 relates to another call placed to the R.N.C. on February 4, 2000 indicating that Darryl was suicidal. When the officers arrived and spoke to Mr. Power he informed them that he did not need any help and was upset because of a call made to psychiatry.

File 2000-0482 relates to an allegation by Catherine Power on February 5, 2000 that Darryl was at her residence and was beating things up. She felt that he needed psychiatric help and she was upset and crying. Responding officers detained Mr. Power under the Mental Health Act and took him to the lock up to be seen by a doctor.

File 00-0616 and File 2000-0527 relate to a prisoner exchange on February 6, 2000 where in Mr. Power was transported from Corner Brook to St. John's. Mr. Power was to be hospitalized at Waterford Hospital. He was allegedly shackled while seated in the police vehicle during the trip from Corner Brook to Gander where he was turned over to a member of the R.C.M.P. for transport to St. John's.

File 00-41896 related to a call placed by Mr. Cyril Power to the R.N.C. on September 23, 2000. Darryl was agitated by noise in the upstairs apartment. Responding officers detained Darryl for breach of peace as Darryl indicated them that he wanted to go to the lock up for the night.

File 00-42189 relates to report received from employees of the Western Memorial Regional Hospital on September 24, 2000 reporting that Darryl was missing from the psychiatric unit. Darryl had signed himself in at 5:00 AM that morning but self-discharged later that morning and returned to his mother's apartment.

File 00-42358 relates to a call placed by Catherine Power to Western Memorial Regional Hospital on September 26, 2000. The matter was referred to the dispatcher at the R.N.C., Constable Ogden, who dispatched two officers to attend at 21B Westmount Road. Constable Haskell and Constable Rideout attended and spoke to Darryl who indicated that he was okay. The officers left without incident.

File 00-45634 relates to a call placed by the Western Memorial Regional Hospital to the R.N.C. several hours after the shooting incident on October 16, 2000 wherein Mr. Cyril Power was very upset at the hospital and causing a disturbance. This was the last file involving Mr. Power or his family referred to at the Inquiry."[43]

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[43] James Walsh, Inquiry Brief, at 17-22.

9.2 October 15-16, 2000

a. Events at Catherine Power's Apartment

In his last week, Darryl Power was very depressed and frequently stayed over at his mother's apartment on Westmount Road. Darryl Power had slept more than usual on October 15th. He was really quite low.

Catherine Power, herself, was not feeling well on account of a stomach flu and had gone to bed around 10 pm. While she was asleep, Darryl Power phoned for a taxi to deliver a dozen beer at approximately 1 am. Darryl Power consumed a few of them.

At 4:15 am, Catherine Power was awakened by the sound of glass breaking. She left her bed to see her son sitting down in the living room. Darryl told his mother that he had eaten some glass. Also, Catherine Power described a cut on his chest or stomach area as a scratch. Darryl Power confessed to his mother that he had cut himself with a knife but "couldn't do it". In other words he could not kill himself with the brown-handled knife.

Catherine Power told us she was nervous and scared, not having seen her son, Darryl, like this before. She said that it was the most depressed and suicidal he had ever been.

After turning off the PlayStation, Darryl Power phoned the Crisis Centre Line. Following that brief call, there was a call to W.M.R.H. (See next section).

Catherine Power related that her son kissed her on the cheek and assured her "I'd never hurt you". Mrs. Power claims to have called the R.N.C. station twice, not getting an answer. Technology does not substantiate that assertion. She told her son to put away the knife, but he did not.

Within five or six minutes, after the next phone call from Constable Ogden to Darryl Power at 5:12 am, Catherine Power put on her coat and went outside where she was met by Constable Haskell and Constable Roche. There is no evidence that Darryl Power threatened or assaulted his mother that night.

b. Phone Call to Western Memorial Regional Hospital

Catherine Power was adamant that it was her son, Darryl, who called the hospital just after 5 am. She very firmly denied making the call. It is difficult for us to understand fully how this tragedy has so affected her. Mrs. Power was emotional during her testimony. Her grief is very real. She revealed that the "whole incident has overwhelmed her, she is now on medication and has never been the same".[44] It is my belief that Catherine Power feels a sense of responsibility for having phoned the hospital and a sense of guilt for the subsequent events. Maybe her denial is her way of dealing with the pain.

The Inquiry accepts the submission of counsel for Western Health Care Corporation.

> "It is submitted that there can be no real issue about who made the telephone call for the ambulance shortly after 5 a.m. on October 16, 2000. For her part, Mrs. Power denies making the call and instead asserts that it was Darryl who called for the ambulance. On the other hand, the Inquiry has heard the evidence of ambulance operator Cless Ollerhead, as well as the evidence of the four other persons who were in near proximity to him when he took a call for ambulance assistance on the morning in question.
>
> Mr. Ollerhead told the Inquiry that when he answered the telephone and identified himself, the caller, who sounded upset, identified herself as

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[44] William Collins, Q.C., Inquiry Brief, Volume 1, at 48.

Catherine Power. Mr. Ollerhead states that the caller told him that her son had been drinking, taking pills and acting strange. Discussion ensued as to whether her son wold come to the Hospital, whereupon Mrs. Power indicated that she thought he should go to the Hospital but that he wouldn't go. Mr. Ollerhead asked Darryl's age, and upon learning that he was 23, pointed out that he could not be forced to come to the Hospital. When Mr. Ollerhead raised the suggestion of calling the police, he could hear Darryl in the background forcefully making the point that the police were not to be sent. It is shortly after this point in the conversation that, according to Mr. Ollerhead, Mrs. Power started crying and telling Darryl to "put the knife back in the drawer". After confirming the address and phone number and Darryl's name, Mr. Ollerhead advised Mrs. Power that he would get back to her.

Mr. Ollerhead told the Inquiry that due to the apparent nature of the call, he was repeating back much of what he was being told, and of course most or all of this was heard by the other Hospital personnel standing or sitting nearby. Without recapitulating in detail the evidence of those other witnesses, it is submitted that their evidence, taken with Mr. Ollerhead's, unequivocally establishes the following facts:

(i) that the phone call was from a Catherine Power of 21B Westmount Road;

(ii) that the caller was calling in relation to her son;

(iii) that the caller advised that her son had been drinking, taking pills and was acting strange;

(iv) that the caller advised that her son was not agreeable to come in to the Hospital; and

(v) that the caller's son was in possession of a knife.

It is reasonable to ask: (i) Why would Cless Ollerhead have been saying the things he was reported by the nearby witnesses to have been saying if he was speaking with Darryl Power? (ii) How can the nearby witnesses have formed the impression that Cless Ollerhead was speaking with a mother who was calling about her son if Cless Ollerhead was speaking with Darryl Power? and (iii) Why would Cless Ollerhead have been using the pronoun "he" if he was speaking with Darryl Power? There are any number of other logical questions which might be asked to underscore the simple point, amply established on the evidence, that it was Catherine Power who made the

> telephone call to the Western Memorial Ambulance Department shortly after 5 am on October 16, 2000."[45]

c. R.N.C. Telecoms

The complement of officers on duty that night is outlined as follows:

> "At the time, four R.N.C. members were on duty within the Corner Brook Division. One of these members, Constable Ogden, was detailed to the Communications Centre. Ordinarily, one member assigned to the Communications Centre would be sufficient to handle calls for service and dispatch these calls to the members on patrol. As it turned out, given the extraordinary nature of this event it no doubt overtaxed the ability of Constable Ogden to fully maintain telephone contact while contemporaneously relaying and receiving vital information via the police radio system."[46]

A detailed account of the communications has been put together by counsel for Constable Haskell[47] and is reproduced as part of this report:

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[45] Paul McDonald, Inquiry Brief, at 16-18.

[46] Paul Noble, Inquiry Brief, at para. 14.

[47] George Murphy, Inquiry Brief, at 29-35

"SEQUENCE OF CERTAIN MATERIAL EVENTS BETWEEN 5:04 (26) AND 5:29 (28) ON OCTOBER 16, 2000

Time	Event
5:04 (26)	Bernadette Flynn calls Constable Ogden to report that Cless Ollerhead had taken a call from Catherine Power of 21B Westmount Road, who was complaining that her son, Darryl Power, 23 years old, had been taking sleeping pills, drinking and acting really strange. She also reported that Cless had asked Mrs. Power if she wanted us (presumably an ambulance) to pick her son up but that he didn't want to come in. Bernadette Flynn went on to advise Constable Ogden that Mr. Ollerhead had mentioned to Mrs. Power about the police and when she mentioned the word police, Darryl had taken the knife out of the drawer.
5:05 (29)	Constable Ogden paged members to come to the Comm Centre. At the time, Constables Haskell and Roche were in the R.N.C. detachment. Constable Earles was not in the detachment at the time.
5:06 (30)	Constable Roche radios Constable Ogden to find out what's going on. Constable Ogden replies on radio that they have to go to 21B Westmount; that Darryl Power's mother had called into the hospital looking for assistance and that the nurse had suggested the police and that upon this being suggested to Darryl, he took out a knife from the drawer and the conversation ended and the phone hung up. It's the last they heard.
5:06 (30) to 5:12 (56)	Constables Haskell and Roche, within this time period, had prepared to respond and left for the scene. (Constable Haskell's radio transmission of 5:12 (56) was made after he left the detachment to respond to the scene). At this point in time there is some issue as to exactly what information Constables Haskell and Roche had, but at a minimum, they knew that a call had come to Constable Ogden from the hospital in response to Mrs. Power having called the hospital concerning Darryl. They knew that the last thing that was heard from Mrs. Power was her saying that "Darryl had a knife" or "Darryl, put down the knife" - words to that effect.
5:12 (22)	Constable Ogden places call to Catherine Power's residence for the purpose of speaking to Catherine Power. Darryl Power answers the phone. Constable Ogden asks Darryl on four occasions if he can speak to his mother, however, Darryl will not let him speak to her. Darryl Power's tone indicates, at the very least, that he is agitated and upset and that he doesn't like the police. Constable Ogden is not successful in speaking to Mrs. Power but he does hear her in the background. Call ends at 5:13(13).

5:12 (56) to 5:12 (58)	Constables Haskell and Roche are en route to the scene by this point and Constable Haskell is attempting to reach Constable Ogden by radio. Constable Ogden at this same time is on the telephone speaking to Darryl Power.
5:13 (13)	This is at the end of Constable Ogden's telephone conversation with Darryl Power. Constable Haskell is radioing Constable Ogden to ask him to call Constable Earles' residence.
5:13 (18)	Constable Ogden replies 10 - 4 to Constable Haskell re the request to call the residence of Constable Earles and then relays to Constables Haskell and Roche that he had just spoken with Darryl Power and that he wouldn't let him speak with Mrs. Power but that he did hear her in the background.
5:13 (57)	Constable Ogden calls Constable Earles at his residence and advises him to go to 21 Westmount. Call ends at 5:14(24). While Constable Ogden is speaking to Constable Earles, Constable Haskett or Roche was radioing in to him asking what he (Darryl Power) had to say.
5:14 (30)	In response to the radio transmission from Constable Haskell or Constable Roche, Constable Ogden advised that he had spoken with Darryl and he was pretty upset. Constable Ogden advised that, as a matter of fact, he had been belligerent towards him and wouldn't let him speak with his mother, stating she was outside. He went on to say he didn't know what the circumstances were and that Mr. Power was very uncooperative.
5:14 (42)	Constable Haskell reports they are on Victoria Street (location of Constable Earles' residence) and en route to Westmount.
5:16 (06) to 5:16 (12)	Radio communication between Constable Haskell and Constable Earles where Constable Haskell inquires as to Constable Earles' location and Constable Earles advises he's on Pioneer Street.
5:17 (10)	Constable Roche radios Constable Ogden to advise they are at the scene (21B Westmount Road).
5:17 (46)	Constable Ogden radios to the officers at the scene and says "Yeah boys, ah, extreme caution."
5:19 (05)	Constable Roche radioed Constable Ogden to advise they had Mrs. Power outside and that Constable Haskell (who was the officer in charge) was requesting the presence of a hostage negotiator.
5:19 (08)	Constable Ogden confirms receipt of Constable Roche's radio transmission.

5:19 (16)	Constable Haskell radios Constable Ogden and asks if he can get Darryl on the phone. He also says to Constable Ogden "We're not going in there if he's got a knife and hammer on him." (It can be safely concluded from the timing of this comment, namely 11 seconds or so after the officers had Mrs. Power outside the apartment, as well as other evidence offered at the Inquiry, that the information concerning the knife and hammer came from Mrs. Power.)
5:19 (24)	Constable Ogden responds to Constable Haskell's radio transmission of 5:19 (16) and asks whether he wants him to call Darryl Power or make contact with a negotiator.
5:19 (39)	Constable Haskell responds to Constable Ogden and advises him to get in contact with Sergeant Head and to tell Sergeant Head that Mr. Power's got a knife down inside of his pants and he's also got a hammer in his possession. He goes on to tell Constable Ogden that she (Mrs. Power presumably) says he's pretty ... he threatened to harm the police. Get a hold of Sergeant Head right away. (It can safely be concluded that by this point Constables Haskell and Roche had observed Mr. Power inside his residence putting what they believed was a knife down his pants).
5:20 (31)	Constable Ogden reaches Sergeant Head by telephone and updates him on the situation at 21B Westmount Road and gets permission from Sergeant Head to call in a negotiator (Sergeant Jeff Richards). This call ends at 5:21 (51). Sergeant Head also directed Constable Ogden to notify Inspector Pike as to what was going on.
5:22 (05)	Constable Haskell calls Constable Ogden to inquire if he had reached Angus (Sergeant Head).
5:22 (20)	Constable Ogden radios Constable Haskell to advise that he intends to get in touch with Inspector Pike and then the negotiator.
5:22 (40)	Constable Haskell radios Constable Ogden and says "Everett, we got a guy here who's in the house with two knives (inaudible) with two knives in his hands right now, getting ready to come out here at us. Get a hold of somebody right away." (It can be safely concluded from the timing of this comment and other evidence offered at the Inquiry that by this point Constables Haskell and Roche had observed Mr. Darryl Power in the apartment with the knives in his hands making circular, martial arts-type movements).
5:22 (53)	Constable Ogden responds "10 - 4" to Constable Haskell.
5:23 (06)	Constable Ogden attempts to reach Inspector Pike.

5:24 (00)	Constable Ogden calls Sergeant Head again and advises that he has been unable to reach Inspector Pike. While Constable Ogden is speaking with Sergeant Head, Constable Earles is trying to reach him on the radio. Call ended at 5:24(32).
5:24 (07)	Constable Earles radios Constable Ogden advising him that he need to get an ambulance there right away. (From the evidence of Constable Earles, we can conclude that by this point in time, Mr. Power had been shot by Constable Roche).
5:24 (27)	Constable Earles radios Constable Ogden again to see if he copies the previous message.
5:24 (33)	Constable Ogden, who is now finished his call to Sergeant Head, responds to Constable Earles' radio transmission.
5:24 (36)	Constable Earles repeats via radio transmission to Constable Ogden that they need an ambulance on Westmount right away.
5:24 (43)	Constable Ogden replies "10 - 4" to Constable Earles.
5:24 (47)	Constable Haskell radios Constable Ogden telling him to get an ambulance to the scene right away.
5:24 (54)	Constable Ogden calls the hospital and requests an ambulance to 21B Westmount. He speaks with Bernadette Flynn.
5:24 (59)	Sarah Summers places call to the 911 line, which is answered by Constable Ogden and advises Constable Ogden that a man had been shot behind 19 - 21 Westmount Road. Constable Ogden advises that the police are already there and an ambulance has been dispatched.
5:25 (16)	Constable Haskell radios Constable Ogden again telling him to get an ambulance to the scene.
5:25 (19)	Constable Ogden replies via radio transmission to Constable Haskell that an ambulance has been dispatched.
5:26 (08)	Constable Haskell radios constable Ogden again advising him that he has to get an ambulance to the scene.
5:26 (13)	Constable Ogden radios Constable Haskell to advise that the ambulance is on the way and that he told them to get there immediately.
5:26 (18)	Constable Haskell again radios Constable Ogden telling him to call in Sergeant Head.
5:26 (41)	Constable Ogden calls Inspector Pike again and this time reaches him and updates him on the situation.

5:27 (46)	Constable Haskell again radios Constable Ogden to ask where the ambulance is.
5:28 (06)	Constable Ogden replies to Constable Haskell advising that the ambulance is en route.
5:28 (12)	Constable Haskell radios Constable Ogden and says "Get (inaudible) Head will ya. We got a 10 - 7 here by the look of it." (Note: The evidence indicates that a "10 - 7" refers to a man being down or out of commission).
5:28 (16)	Constable Ogden radios Constable Haskell and acknowledges his previous message and indicates to Constable Haskell that Sergeant Head is on the way. He also advises Constable Haskell that he had just spoken with Inspector Pike and had to get back to him.
5:29 (12)	Constable Ogden radios Constable Haskell to ask if there's any sign of the ambulance.
5:29 (17)	Constable Haskell replies that the ambulance is there at the scene.
5:29 (21)	Constable Ogden radios Constable Haskell to ask him to advise him as to the circumstances when he gets a chance so he can get back to Inspector Pike on it.
5:29 (28)	Constable Haskell radios Constable Ogden and tells him to get back to Inspector Pike and tell him to get in here.

d. R.N.C. Response

Constables Haskell and Roche arrived together at 21 Westmount Road at 5:17 am. Very shortly thereafter, Constable Earles arrived. Constable Haskell was the senior officer present. He and Constable Roche proceeded down the narrow laneway between two houses, 19 and 21Westmount. Catherine Power's apartment 21B was at the back of the house. Constable Earles followed immediately behind. The officers could not see the apartment inside through a window because the blinds were closed.

Within a few seconds, Mrs. Power came out of the apartment and, when asked if Darryl had any weapons, replied that he had a knife and a hammer. At the request of Constable Haskell, Catherine Power was taken to the patrol car by Constable Earles. She had expressed a desire to return to the apartment, but was refused on grounds of her personal safety being put at risk. Constable Earles had Mrs. Power sit in the back seat of the patrol car and for her physical comfort, turned on the heater. There was little conversation between Constable Earles and Mrs. Power, but she did tell him that Darryl had bitten on some glass. Constable Earles then got out of the vehicle to return to his two fellow officers.

In the meantime, Constables Haskell and Roche had looked in through another window (actually a sidelight and an interior window inside a porch-like area) and they could see Darryl Power. It appeared to them that he had been drinking and was agitated and aggressive. Darryl Power made swinging gestures with his arms similar to martial arts movements while holding at least one knife and possibly putting another one inside the waist of his pants. Within a very short period of time, Darryl Power had turned off all the lights in the apartment.

While it was still dark outside, the officers testified that they could see one another mostly due to the ambient lighting from O'Connell Drive and any available natural light from the sky. There were street lights on Westmount Road which probably did not add to the limited lighting in these backyard areas.

Constables Haskell and Roche understood their sworn duty as peace officers to ensure public safety and that is why they remained at the scene. They could not retreat from this scene. Furthermore, they decided not to approach the door and knock because of the threat posed by Darryl Power. Constable Haskell had radioed in, asking for a police negotiator.

e. The Shooting

Constable Roche took up a position behind a small shrub and Constable Haskell situated himself near the picnic table behind 19 Westmount. Constable Roche was 19' 11" (5.98 meters) from the Power apartment door while Constable Haskell's distance was 21' 2" (6.45 meters). This terrain presented enormous difficulties because of the slope down the hill of up to 36 degrees.

Within seconds, Darryl Power, after shutting off all the lights, departed the apartment via the same back door as referred to above. Constables Haskell and Roche had their weapons drawn. Constable Haskell yelled at Darryl Power, ordering him to go back in the house. Darryl Power yelled back, cursing and swearing, demanding that the police leave the area. After looking briefly at Constable Haskell, Darryl turned and looked directly at Constable Roche. Constable Roche spotted a pointed object which he believed to be a knife. Darryl Power had raised his hands about waist high. Darryl Power then continued moving, now directly towards Constable Roche who backed up about as far as he could given the steep slope, a distance of 13' 1" (3.96 meters).

Constables Haskell and Roche both testified that Darryl Power uttered the words, "Shoot me, shoot me." These words were not heard by the neighbours, Sarah Summers and Erin Summers, nor by Constable Earles.

Given the heightened state and many words yelled back and forth compressed into a time span of less than 10 seconds, it is most likely that Constable Earles was not able to pick up exactly on those words - he did not deny that they were said. Again, as to the Summers' ability to hear, they were inside their residence. Sarah Summers specifically only heard the warning of a knife being yelled out; she did not hear the commands for Darryl to go back in the house nor "shoot me". In addition, she testified that as she walked to her bedroom, she didn't hear anything.

Erin Summers, daughter of Sarah, could hear the sound of police radios at the side of her house. Even though her window was open facing the street, she could not tell what was said other than a comment to the effect that an officer thought he had a knife.

Both Constables Haskell and Roche were consistent and adamant about "shoot me, shoot me". Their position was the same throughout from initial statements through to examination and cross-examination at the Inquiry. The Inquiry accepts that Darryl Power, in the depths of despair, did cry out these words.

Within 10 seconds of leaving the safe confines of his mother's apartment, Darryl Power was shot three times by Constable Roche.

It took approximately two seconds for the three shots to be fired, including a very slight pause after the first shot. Darryl Power was no more than 10 feet away from Constable Roche when the shots were fired. Three shots were sufficient to stop the threat, as Darryl Power had stopped his forward movement and fallen to the ground. There was no time to aim. In fact, on the slope, Constable Roche slipped, caught himself and then shot from a stable stance. This was an example of the instinctive shooting which the officers are trained in. Darryl Power was shot once in the chest and twice in the head. The shooting took place at 5:24 am.

Constable Haskett checked for a carotid pulse and thought he felt it. Constables Earles and Haskell called for an ambulance. Sarah Summers called 911.

Constable Haskell told us that he would have shot Darryl Power, but he had some concerns to Constable Earles' location.

Police discovered a black handled knife in the deceased's right hand - the other knife and the hammer lying on the ground nearby. Constable Roche turned his firearm over to Constable Haskell (well -established procedure) who locked it in the trunk of the police vehicle.

In an effort to warm himself, Constable Roche sat inside the patrol car. Constable Haskell stayed with the body. Constable Earles returned to his vehicle and drove Catherine Power to R.N.C. headquarters.

f. Ambulance

Attendants Ollerhead and Butt were dispatched to 21B Westmount Road, arriving there at approximately 5:30 am. Constable Haskell told them to be careful as this was a "crime scene". In other words, the scene could not be disturbed - evidence had to be preserved.

Constable Roche told the attendants, without hesitation, an abbreviated version of what occurred. To them he appeared to be in shock.

The attendants carefully examined the body. There was no pulse, no chest movement, no vital signs whatsoever. Mr. Butt covered the body. There being no further need for the attendants to be at the scene, they left for coffee and returned to the hospital.

g. Scene After Arrival of Extra Police Personnel

After Staff Sergeant Angus Head was picked up by Constable Earles on Brookfield Ave. at 5:40 am he was taken to R.N.C. headquarters where he got a unmarked car and went to the scene by himself, arriving just after 6 am.

Officer Head saw Constable Roche seated in a patrol car and proceeded down the laneway to the scene, where he observed Constable Haskell in a shaken state, pacing back and forth. Sergeant Head and Constable Haskell spoke briefly about the events. Constable Haskell remained at the scene and Sergeant Head took Constable Roche to the nearby Tim Horton's for coffee. They also briefly talked of the incident. Sergeant Head advised Constable Roche not to speak to anyone until he had legal counsel.

The next police officer to arrive at the scene was Constable Dean of the Identification Section followed by constable Biggin who arrived just after Constable Haskell left. Constables Biggin and Dean continued to preserve the scene with the latter taking some photographs.

Constable Ogden had contacted local medical examiner, Dr. Ian Simpson at 5:45 am. Within 35 minutes, Dr. Simpson was on the scene. He spoke with the two Constables, Biggin and Dean, noting that the scene was clearly secured.

Dr. Simpson uncovered the body and, as was his responsibility as medical examiner, took charge of the body, instructing the police to do what they needed to. The photos of the body were very accurate in their depiction.

Shortly thereafter, Sergeant Pauls and Sergeant Tilley arrived. There was no question about the scene being properly preserved. After phoning the Chief Medical Examiner, Dr. Avis, Dr. Simpson arranged with the police for the properly secured body to be transported to St. John's for autopsy.

h. Notification of Death to Family

Counsel for Constable Earles has clearly set out the facts and concerns:

"Constable Earles had returned to R.N.C. headquarters with Mrs. Power and placed her in the breathalyzer interview room while she waited for other family members to arrive. Telephone contact was made with one of her sisters who resided in a community near Corner Brook. Constable Earles kept returning to the room where Mrs. Power was located to check on her until her family members arrived.

Exhibit CK#18, outlines the R.N.C. policy with respect to firearms. Article 15, at Page 9, outlines the protocol with respect to shooting incidents. Article 15(b) indicates, in part, that the R.N.C. must attend to the following matters:

> (2) the psychological care of all involved members.

Article 15(d) indicates, in part, that:

> (3) members directly involved in shooting incidents will leave the scene as soon as possible and not be assigned further duties regarding the incident. (Emphasis added)

Unfortunately, the N.C.O. in charge and the District Commander failed to strictly adhere to article 15(d)(3) with respect to the notification of Mrs. Power and her family members by leaving this task to an incident officer, namely Constable Earles. The N.C.O. in charge failed to recognize, or establish, that Constable Earles was a member directly involved in the shooting incident. The district commander failed to assign another member, including himself, the task of informing Mrs. Power that her son Darryl had died in the incident. Both officers failed to take advantage of an opportunity presented to them by Constable Earles when he informed them that the sister of Mrs. Power had arrived, that Constable Earles was about to inform Mrs. Power of her son's death, and without much thought still permitted Constable Earles to deal with the notification.

When the sister of Mrs. Power arrived at R.N.C. headquarters she was met by Constable Earles who immediately informed her of the incident involving Darryl Power that unfortunately led to Darryl's death. She asked that she be able to go to her car and get her daughter to be with her, which she did and returned to headquarters. Constable Earles then informed the daughter that Darryl had been shot and killed by a police officer. Constable Earles sat down next to Mrs. Power and informed her, in a very sensitive and professional manner, that Darryl had attacked one of the officers and the officer was forced to shoot Darryl. He then informed her that Darryl was dead. As expected, Mrs. Power became very emotional

> and lost control of her emotions. Shortly thereafter, Mrs. Power her sister and her niece left the building."[48]

Counsel for the R.N.C. acknowledges that "it was regrettable that Constable Earles, as one of the incident officers, found himself in the position of notifying Mrs. Power of her son's death. The R.N.C. will amend its Policy and Procedure Manual to ensure that incident officers are not placed in such circumstances in the future."[49]

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[48] James Walsh, Inquiry Brief, at 44-45.

[49] Paul Noble, Inquiry Brief, at para. 34.

9.3 Autopsy

a. Report

The autopsy on the body of Darryl Power was conducted on October 18, 2000, at St. John's, by Dr. Simon Avis, Chief Medical Examiner. His appointment and duties are set out in section 3 of the *Fatalities Investigations Act.*, S.N.L. 1995, c F - 6.1. The autopsy report has been exhibited as SA#2. It contains the following:

FINDINGS:

1. Multiple gunshot wounds:
    1. left maxilla
    2. left temple
    3. Right chest

CAUSE OF DEATH:

Gunshot wounds to head.

MANNER OF DEATH:

Homicide

TOXICOLOGY:

Blood ethanol = 17 mmol/L.

Drug screen: see attached Forensic Laboratory Report

The lab report showed Paroxetine and Ibuprofen in the blood. In the urine, there were detected Paroxetine, Ibuprofen and Salicylic Acid. The level of Paroxetine in the blood was higher than the normal therapeutic range.

Dr. Avis explained the alcohol level to be 78 milligrams of alcohol in 100 milliliters of blood. Paxil (Paroxetine) was at twice the therapeutic level.

Dr. Avis advised that there are very rarely overdoses on Paxil and that the Paxil would not have affected his cognition. He was unable to say that, combined with the alcohol, there was no effect.

The chest wound was not fatal. The gunshot wounds to the head were.

b. Victim Precipitated Homicide

Dr. Avis has investigated hundreds and hundreds of suicides, reviewing every one of the 50 to 75 per year in the province. He is quite familiar with the concept of "suicide by cop" or "victim precipitated homicide" (VPH). As many as 13% of police fatal shootings are VPH.

In reviewing the file, including Darryl's notes, Dr. Avis detected the themes of depression, hopelessness and death. He noted Darryl Power never had a diagnosis of psychosis and that he did not lose contact with reality.

"Shoot me, shoot me" was an important factor for Dr. Avis in determining whether or not this death was VPH. If this occurred, his opinion was definite that this was, in fact, "suicide by cop". Dr. Avis would not have been as certain if those words were not uttered by Darryl Power.

Psychologist Ross Loomes was of the view that Darryl Power's death was "suicide by cop".

Dr. Peter Collins is Staff Forensic Psychiatrist, Specialty Services, Law and Mental Health Programme, Centre for Addiction and Mental Health (Clarke Institute of Psychiatry Division). He is also the Manager, Forensic Psychiatry Unit, Behavioural Sciences Section, Investigation Support Bureau, O.P.P. At the University of Toronto, Faculty of Medicine, he is an assistant professor at the Department of Psychiatry, and at the Mississauga Campus of University of Toronto, he is an assistant professor at the Division of Sciences.

Dr. Collins was provided with volumes of material including Darryl Power's health and social records from Ontario, O.P.P. investigation volumes 1-3, medical records from Newfoundland, and a statement from Ross Loomes.

The report of Dr. Collins was entered as exhibit PC#2. His opinion, expressed on page five of that report, was that "the death of Darryl Power was consistent with law enforcement assisted suicide or "suicide by cop". ... Mr. Power knew that his actions would likely result in the police having to shoot him especially when he ignored their commands and kept approaching with weapons ... He could have returned to the house, dropped the weapons or stopped when commanded to, but chose not to."

Under extensive cross examination, he conceded that some factors such as writings about the future would be inconsistent with suicide, but maintained his view that this was "suicide by cop".

As I indicated above at page 104, most of the future plans were unrealistic and I believe Darryl Power knew this to be so.

I agree with Dr. Sayeed's characterization of Darryl Power's suicide ideations as being in the 2nd and 4th categories.

It is fair to say that past suicide attempts were not designed to succeed, rather they were to get attention. Even within an hour or two of his death, Darryl Power did not have the will to complete the act with a knife or broken glass. While Darryl Power had mentioned or written in the past on a few occasions that a good way to die would be by police shooting, he had no definite longterm plan to ensure this would happen. Nor do I think he was preoccupied by this means of suicide.

Darryl Power had, since his return from Ontario, an up and down relationship with the R.N.C.. As a result of a prisoner escort to Gander from Corner Brook in February 2000, wherein he claimed mistreatment by the R.N.C. because he was shackled, Darryl Power had a deep resentment towards the local police for the most part. There was however, an encounter without incident on September 26, 2000, with Constables Haskell and Rideout.

As the events of October 15-16, 2000 reveal, the deep resentment of the police was clearly evident, particularly in the recorded phone call between Constable Ogden and Darryl Power just 11 minutes before his death. We listened to that tape several times. It revealed strong, negative emotions of Darryl Power consistent with his dislike of the police. To have heard the actual voice of Darryl Power within a few short minutes of his death was truly a somber experience. This real evidence was of considerable benefit to the Inquiry.

I agree with the submission of counsel for Constable Haskell:

> "On October 15th - 16th, 2000, Mr. Power was suffering through a very difficult period of despair, characterized by a desire to die so that he would be free of the pain he so frequently suffered. He had made an attempt at suicide, but could not bring himself to complete the act. While in this state of mind, an opportunity presented itself which allowed Mr. Power to both lash out at the police and, at the same time, bring about his own death by having the police shoot him. It is not being suggested that Mr. Power orchestrated events so that the police would respond to his residence. Instead, when he realized the police were outside his residence, he impulsively decided to go outside and attack them with two knives and a hammer, knowing he would force the police to shoot him, as he had though about and mentioned to others on previous occasions."[50]

Counsel for the Power family quite capably and forcefully attacked the applicability of victim precipitated homicide or "suicide by cop" to this sudden death.[51] The Inquiry has decided otherwise.

The only consolatory step I can take in the direction of the family's strongly held position is to state:

> "It is virtually impossible to prove anything to an absolute certainty ... Such a standard of proof is impossibly high.
>
> A reasonable doubt is not an imaginary or frivolous doubt." *"It must not be based upon* ***sympathy or prejudice****."*(my emphasis added) "Rather it is based on reason and common sense. It is logically derived from the evidence or absence of evidence." (Quotes from *R v. Lifchus*, [1997] 3 S.C.R. 320).
>
> I agree with the position advanced by David Day, Q.C., that the standard of proof at inquests or inquiries falls somewhere between a "preponderance" and "proof beyond a reasonable doubt" and could be characterized as "clear, strong and convincing".[52]

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[50] George Murphy, Inquiry Brief, at 101-102.

[51] William Collins, Q.C., Inquiry Brief, at 190-197, 220-230, 280-285, 295-297, 308-317, 381-384.

[52] David C. Day, Q. C., Inquiry Brief, at 34.

The family may well disagree with my finding which has been made on the basis of evidence which I have found to be "clear, strong and convincing". The theory of "suicide by cop" has not been proven to an absolute certainty in this instance.

This type of death was not the fulfilment of a plan Darryl Power had formulated. Rather, the opportunity suddenly presented itself. He was angry, depressed and in utter despair. His troubled and tormented mind put together this impulsive action within a very short time, possibly less than five minutes. These short-lived, deliberate and aggressive actions, while armed with three weapons, resulted in his sudden death - "suicide by cop".

10. R.N.C. Investigation

The investigation conducted by the R.N.C. into the death of Darryl Power (same day and then being sworn in as special constables of the R.N.C. next afternoon), was according to the book and not subject to criticism nor adverse comment, except for the issue about the incident officers being alone together. That issue will be addressed after a general outline of the R.N.C. investigation.

> "Within hours of the shooting incident on the morning of October 16, 2000, an investigative team was assembled out of R.N.C. headquarters in St. John's, to initiate the investigation into the circumstances surrounding the death of Darryl Power. This team was led by Inspector Craig Kenny, an experienced CID investigator. The team included two CID investigators, Sergeant Mark Wall and Constable Barry Randall, two members from the R.N.C. Technical Investigations Unit, Sergeant Harry French and Constable Roy Hoskins, and a member from the R.N.C. Forensic Identification Services, Sergeant Wayne Hamum. Sergeant (now Inspector) Robert Garland, the R.N.C. Media Liaison Officer and Coordinator of the Employee Assistance Program, also traveled to Corner Brook, as did Sergeant Kerry Swain from the R.N.C. Internal Review Section.
>
> A St. John's Psychologist, Dena Orr, also traveled with the team to lend her professional services to the incident officers pursuant to R.N.C. Policy.
>
> The mandate of the investigative team from St. John's was to assume responsibility for the investigation and continue the work initiated by members of the Corner Brook Division of the R.N.C. in canvassing the area for witnesses and preserving and securing physical evidence.
>
> The R.N.C. investigation was conducted on the basis of the Major Case Management Model which is an investigative method widely accepted in Canada for the investigation of serious matters."[53]

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[53] Paul Noble, Inquiry Brief, at para. 36-39.

The R.N.C. work was professional and thorough. Inspector Kenny had been contacted within 75 minutes of the death. Shortly thereafter, he assembled his team and spoke to the Chief Medical Examiner. They arrived from St. John's at 11:30am, participated in briefings and were on the scene at 3:50 pm. Inspector Kenny talked to Dr. Avis again at 4:15 pm. He also received a legal opinion from Senior Crown Attorney, Del Attwood, that they did not need a warrant. Later, he and Constable Randell interviewed the four incident officers, Ogden, Haskell, Roche and Earles.

Earlier in the afternoon, Inspector Kenny had a discussion with Cyril Power who was touting the notion of a cover-up. Mr. Power was told about the O.P.P. conducting the investigation and the likelihood of a judicial inquiry.

Around 11 pm the same day, Inspector Kenny picked up the five O.P.P. officers at the Deer Lake Airport and briefed them on their journey to their Corner Brook hotel.

Counsel for the family had concerns on the issue of the incident officers being alone together. I agree only partially with him. Counsel for the R.N.C. point out:

> "It must be emphasized that these members **were not suspects** in the sense of being implicated in the commission of any criminal offence. We believe that following such a traumatic event it was appropriate for them to be with one another and to lend support to each other through their combined presence."[54]

Counsel for Constable Earles correctly observed that 'there was no legal right to otherwise restrict the movements of the incident officers'."[55]

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[54] Paul Noble, Inquiry Brief, at para. 40.

[55] James Walsh, Inquiry Brief, at 50.

There was no evidence before the Inquiry that there was any inappropriate discussion or collusion on the part of the incident officers. Nonetheless, public perception of police activities is especially important in these rarest of events in our province. To avoid any possibility of public skepticism or concern, real or imagined, it is far better to err on the side of caution. Consequently, it would be better to have an outside person, perhaps a clergyman or counsellor, to be with the incident officers while they are together to assist them and to be in a position to confirm to the public that they are not "getting their stories straight". While the incident officers are not together, they should be totally free to do as they please.

There was some criticism of Constable Ogden terminating the call with Darryl Power. Upon analytical review, it was felt that it would have been better for Constable Ogden to have further engaged Darryl Power in conversation in an effort to diffuse the situation over time, perhaps permitting the arrival of a police negotiator, and definitely giving Constables Haskell, Roche and Earles opportunity to develop a plan.

I am reluctant to find significant fault with Constable Ogden's work at the Telecom Centre. While trained in this field, it is not his primary area of expertise. Further, Darryl Power was very difficult on this call.

Mental Health Crisis Line workers terminate calls if the caller is abusive. Given Darryl Power's feelings towards the police, it is doubtful whether prolonging the call would have had any beneficial effect, if indeed the call could have been prolonged more than just a few seconds.

11. O.P.P. Investigation

No particular issues of any consequence arose with the manner in which the O.P.P. did its work. The wisdom of already having in place the established protocol with the O.P.P. for such major incidents was borne out in an abundantly clear fashion in this investigation. This Memorandum of Understanding or something similar should continue to be renewed. It serves our people well.

The details of the O.P.P. investigation are well summarized in the submission of counsel for Constable Earles.

> "Detective Inspector Clifford Strachan is a 26 year member of the O.P.P. currently assigned to the criminal investigation branch at Orillia, Ontario. On October 16, 2000, he was assigned the responsibility to conduct the investigation into the death of Darryl Power. Included in this duty was that he was the case manager and responsible to put together an investigative team. After reading the Fatalities Investigations Act, Det. Insp. Strachan believed that it was his duty to act under the direction of the Chief Medical Examiner, and he did so. If he noticed any criminal issues arising it was his responsibility to be in charge of any criminal investigation as well.
>
> Det. Insp. Strachan initially selected four officers to join him on the investigative team and, later, added Constable Paul Rosato, an identification specialist, to the team. The O.P.P. took over the investigation at approximately 4:00 PM on October 17, 2000. He sent one of the O.P.P. officers, Detective Inspector Ian Grant, to St. John's to attend the autopsy.
>
> Walk through statements were obtained from Constable Roche, Constable Haskell and Constable Earles October 19, 2000. These statements were taken at the scene, were videotaped, and were conducted primarily by Det. Insp. Ian Grant.
>
> As part of the investigation a check was done with other police agencies in Ontario with respect to any dealings they may have had with Darryl Power (CS#1). A search of Mr. Power's apartment and the apartment of Mrs. Power resulted in the collection by the R.N.C. and the O.P.P. investigators of Darryl's personal writings (CS#3; CS#4). These writings had frequent entries referring to suicidal thoughts.

Det. Insp. Strachan and his team completed their investigation through a thorough review of statements obtained from all relevant witnesses including incident officers, Mr. Power's neighbors, Mr. Power's parents, the ambulance attendants, taxi driver, emergency department nurses and physician, other hospital personnel and many others who had been in contact with Mr. Power. They were also able to obtain his medical information in the province of Ontario as well as some information in the province of Newfoundland, which information was passed on to Dr. Peter Collins for the purposes of reviewing the possibility of suicide by cop. Further, they reviewed Mr. Power's contacts with police agencies in the provinces of Ontario and Newfoundland, as well as his Court record.

The final report was submitted by the O.P.P. to the Chief Medical Examiner and to the Newfoundland Department of Justice. The report concluded that there was no criminal offense committed by any of the incident officers and that Constable Roche was justified in discharging his firearm to defend his life. Det. Insp. Strachan concluded that use of force was the only option available to Constable Roche under these circumstances. This opinion was further supported by Sgt. Darrell Knox, the use of force trainer for the O.P.P. in Orillia, Ontario, who stated as follows:

"... I find this to be a justifiable shooting. The officers involved resorted to the use of lethal force only as a last resort. The officers used a number of less than lethal tactics to bring the situation to a safe conclusion. Darryl Power was given an opportunity to drop the knife and be taken into custody without further incident."

Further, there was no breach of R.N.C. policy and, the actions of the officers were completely in accordance with the R.N.C. policy. Dr. Avis and the Newfoundland Department of Justice concurred with the conclusions of Det. Insp. Strachan."[56]

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[56] James Walsh, Inquiry Brief, at 52-54.

12. Issues of Legislation

These issues have been addressed in the report into the sudden death of Norman Reid.

13. Issues of Health Care

These issues have been addressed generally in Section I of this report and also in the report into the sudden death of Norman Reid.

Counsel for Western Health Care Corporation has advised of two projects one of which has already been completed; the other has been approved for construction.

> **"Therapeutic Quiet Room**
>
> The Inquiry has heard evidence that very often, mentally ill persons who are acting out have been brought to the police lock-up in order to be assessed, or that persons on the Psychiatry Unit at the Hospital who are acting out have had to be transferred to the police lock-up, in the interest of safety of other patients. Western Health Care Corporation agrees that placing or holding mentally ill persons in the police lock-up is an unacceptable and counterproductive practice. The corporation wishes to advise the Inquiry that a new, secure Therapeutic Quiet Room has in fact now been installed on the Psychiatry Unit at Western Memorial Regional Hospital. It is intended that the Therapeutic Quiet Room can be used as a safe and secure holding area for mentally ill persons brought to the Hospital by police, and as a safe and secure place where Unit inpatients who have become violent can be settled down. The Therapeutic Quiet room now installed at the Hospital will hold one patient at a time, and this patient will be able to be observed both through a special window and an unobtrusive video camera. This project had in fact been approved at least a couple of years ago, but was delayed while the project competed with other demands on the labour budget within the Hospital.
>
> **A Smoking Area**
>
> At one point during Inquiry hearings it was suggested by counsel for one or two of the parties that the provision of a designated smoking room on the Psychiatry Unit would avoid those inevitable difficulties which arise when a Psychiatry Unit patient wants to go outside to smoke, but there is no one available to accompany the patient. Western Health Care Corporation wishes to advise the Inquiry that plans have been approved and space has been set aside for the installation of a smoking area on the Psychiatry Unit at Western Memorial Regional Hospital, and this smoking area is now awaiting construction. The delay in construction arises from the same factor which caused a delay in the construction of the Therapeutic Quiet Room, ie, project prioritization in the Hospital's labour budget. The Corporation will

not be providing similar smoking areas to other parts of the Hospital, and accordingly smoking privileges will be confined to the Psychiatry Unit and Palliative Care."[57]

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[57] Paul McDonald, Inquiry Brief, at 22-24.

14. Issues of Policing

14.1 Training

a. Use of Force Continuum

The Inquiry is satisfied that R.N.C. officers, including the incident officers, have been adequately trained in use of force. The present model, "National Use of Force Model", was adopted by the R.N.C. in 2001 with the input of academics and leading police trainers, including Inspector James Carroll.

The training programme of the R.N.C. in this subject area is consistent with Ontario, British Columbia, R.C.M.P., etc. It also adheres to the principles set out by the United Nations in its Code of Conduct for Law Enforcement Officials and Use of Force and Firearms by Law Enforcement Officials.

The expert from the Ontario Police College, Chris Lawrence, did not fault the three incident officers in their response to Darryl Power's threat.

b. Mental Illness

Please refer to the commentary in the report into the sudden death of Norman Reid.

Everyone recognizes that more training for police, judges, social workers, nurses, ambulance attendants, doctors, etc. in this subject area would be beneficial.

Constables Roche, Earles and Haskell readily admitted to not having had formal training in "dealing with people suffering from major mental disorders". These officers were generally aware of some of the services available to mentally ill persons and they generally relied on their experience and common sense in handling a situation of this nature

Counsel for the C.M.H.A. summarized the current state of R.N.C. training in this subject area:

> "Acting Superintendent Sean Ryan of the R.N.C. was qualified as an expert in regard to police training on the subject of mental illness. In early 2001, he was tasked to discover the then training methods of the R.N.C. with respect to mental illness issues and to determine what, fi any, other training is required to keep R.N.C. officers up to date and responsive to persons with mental illnesses. His evidence was that there was no training of recruits, cadets or in-service training of officers prior to the summer 2000 with respect to mental illness issues. Training prior to summer 2000 focused on Use of Force training, specifically with de-escalation and verbalization training that every officer goes through.
>
> The gist of A/S Ryan's evidence was that in the nearly two year period of his review process he has traveled and attended many conferences, and has acquired an extensive collection of training modules from across Canada (Exhibit SR#2). However in the time that he had been tasked, he referred to his research as a "work in progress", as being mid way through. He indicated that he had no time line within which he was to provide a conclusion to his task, but stated "as soon as practical".
>
> Despite the extensive nature of the research and material accumulated, A/S Ryan stated that he was not prepared to commit to any one program because it may not necessarily apply wholly to Newfoundland. A/S Ryan did indicate however that a core of basic training for officers would include
>
> Some awareness of some of the illnesses and clarification in simplistic terms on some symptoms and signs of the illnesses in conjunction with the intervention skills and, of course, followed up from a less lethal options perspective (Transcript Reid & Power Inquiries, Volume X, page 203, lines 2-5)
>
> A/S Ryan confirmed that he had the authority to identify training areas that were not adequate and to make the appropriate adjustments to the program. However, even such core basic training as identified by A/S Ryan has not been implemented with the Royal Newfoundland Constabulary.
>
> Thus, as of the date of his testimony on December 13, 2002, A/S Ryan has identified that further training of R.N.C. officers is needed, however there has been no such training program or proposal developed with respect to mental illness issues, and there was no sense as to whether or when such a program would be developed. This leaves one to wonder as to the priority, importance and significance placed by

> the Royal Newfoundland Constabulary on training of front line officers and the response to mental health crisis situations."[58]

The R.N.C. quite clearly recognizes the need for training and is eager to include the perspective of the C.M.H.A. in developing a good, sound training model.

Counsel for the R.N.C. discussed the type of training that would make sense:

> "Acting Superintendent Ryan emphasized that police training vis-a-vis mental illness and disorders will not place police in the position of being able to diagnose mental illnesses and respond accordingly. This was also a sentiment reiterated by most mental health care professionals who testified at the Inquiry. Rather, the prevailing though in this regard is that such training be realistic and applicable to the frontline officer in the sense that it raise and discuss awareness of some of the more common illnesses and disorders; clarify in simplistic terms some of the common symptoms and signs of such illnesses and disorders; and teach the more proven and pragmatic intervention skills relative to such behaviours."[59]

In the recommendations following, I will significantly address the issues of priority and training.

Given the sudden aggressive movement of Darryl Power, it is unlikely that either advanced police training in dealing with mentally ill persons or usage of intermediate weapons would have resulted in a different outcome.

c. Information DataBase

Obviously, the more information responding police officers have when they approach a most difficult situation like this, the better. The informal, ad hoc "system" in place now, should be reviewed with the goal of establishing a database, consistent with principles of medical confidentiality, so that relevant, important information for police agencies is made available.

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[58] Sandra Burke, Inquiry Brief, at 58-59.

[59] Paul Noble, Inquiry Brief, at para. 70.

15. Conclusion

In the early morning hours of October 16, 2000, Darryl Power was staying at his mother's apartment. He was a 23 year old man suffering from severe depression and had recently been diagnosed with borderline personality disorder. His mother was doing her best to care for her troubled son.

Having consumed beer to bring his blood alcohol content to .78 and having ingested twice the therapeutic limit of Paxil, Darryl Power cut himself and also ate some glass. He, himself, could not complete the act of suicide.

At 4:15, am his mother, Catherine Power, was awakened by the sound of glass breaking and was most concerned for her son. Darryl Power phoned the Mental Health Crisis line and was on the phone for just over five minutes.

Around 5 am, Mrs. Power called the hospital requesting an ambulance. During the call, she was heard telling her son to put down the knife. This and other information was repeated by Cless Ollerhead, ambulance attendant, to other staff in the same room. Nurse Bernadette Flynn phoned the R.N.C. headquarters which, in turn, dispatched three police officers to Catherine Power's apartment.

Upon arrival at the scene, the police were met outside by Mrs. Power. She was taken to a patrol car. After arming himself with two knives and a hammer, Darryl Power turned off the lights to his apartment and, with little hesitation, ran directly towards Constable Roche in a very aggressive and threatening manner.

At 5:24 am, Constable Roche fired three shots with his firearm, one to the chest and two to the head and, within a minute, Darryl Power was dead.

Darryl Brandon Power died at 5:25 am, on October 16, 2000, at Corner Brook, Newfoundland and Labrador. The cause of death was gunshot wounds to the head.

The manner of death was homicide - victim precipitated homicide.

PART 3 - RECOMMENDATIONS

16. Recommendations

16.1 Introduction

Throughout this report, the majority of commentary and recommendations have been addressing issues of mental health, followed by those of policing, social services and others. It is beyond the scope of the Inquiries to make recommendations on issues not directly related to the sudden deaths of Norman Reid and Darryl Power. Tangentially, numerous issues have been implied and discussed. Nonetheless, while necessarily broad in scope, because of the numerous subjects stemming directly from these fact situations and tempting as it may be, we are not out to universally suggest changes and improvements except insofar as they may prevent future similar sudden deaths.

> "Inquests or fatality inquiries into the death of a person with a mental illness, or the death of others attributed to a person with a mental illness, often touch on issues of mental health legislation. The purpose of an inquest is to discover the cause of death. However, juries often hear evidence from which they make recommendations for changes in mental health legislation. Examples of juries making recommendations to government to broaden *Mental Health Act* admission criteria or introduce out-patient compulsory treatment are not unusual where people have killed themselves or others (e.g., Brian Smith in Ottawa killed by a deluded untreated person with schizophrenia;[60] Ruth Millar stabbed with a ceremonial sword by her unmedicated schizophrenic son;[61] and two-year-old Zachary Antidormi killed by a lady who suffered for many years with untreated paranoid schizophrenia[62]). While governments are not bound by recommendations of coroner's juries, it would appear that they have had some influence. For example, a bill amending the Ontario *Mental*

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[60] Ontario Ministry of Solicitor General Verdict of Coroner's Jury on the Inquest into the Death of Brian Smith, Nov., 1997.

[61] Coroner's Court of British Columbia Verdict at Coroner's Inquest into the Death of Ruth Elinor Millar, March 1998.

[62] Ontario Ministry of Solicitor General Verdict of Coroner's Jury on the Inquest into the Death of Zachary Antidormi, October 1999.

Health Act was named after the victim of a person with untreated schizophrenia where the Coroner's jury made recommendations for amending the Act."[63]

The people of Newfoundland and Labrador expect and should accept no less than comprehensive legislative reform with a new *Mental Health Act* passed and proclaimed into force within seventeen months, i.e. no later than June 30, 2005.

16.2 Perspective

Recommendation #1

IT IS HEREBY RECOMMENDED that to poignantly put all of these issues into a proper historical perspective that the Minister of Justice and the Minister of Health and Community Services read the compelling evidence of Anne Marie Hagan whose father, Thomas Hagan, was brutally killed in 1979, by a man suffering from severe mental illness. This man viciously struck Mr. Hagan no less than sixteen times with an axe in the presence of our witness, Anne Marie Hagan. The Inquiry Report was filed with government in 1980. Anne Marie Hagan's testimony is included in this report as Appendix "D".

16.3 *Mental Health Act*

Given the pathetic history of no legislative reform since the Hagan Inquiry, I am taking the unusual step of setting out a timetable which the citizens of Newfoundland and Labrador can readily monitor, and which provides a definitive measure of accountability.

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[63] Brian's Law (Mental Health Legislative Reform), 2000, S.O. 2000, c. 9.

Some degree of guidance has been realized from the Lester Donaldson Inquest Jury Recommendations of July 7, 1994, (Ontario) particularly #84 and 85 at pages 30 and 31.

RECOMMENDATION #2

IT IS HEREBY RECOMMENDED that

a) the Minister of Health and Community Services arrange for a regional forum of public consultation to take place in not less then four centres during May or June of 2004, to discuss a new *Mental Health Act* taking into account various policy and other papers already prepared, this report, and any other relevant information.

b) the Minister of Health and Community Services host a provincial conference on a new *Mental Health Act* during the month of September or October 2004.

c) the Government of Newfoundland and Labrador introduce the new *Mental Health Act* to the House of Assembly not later than March 2005.

d) the new *Mental Health Act* be proclaimed into force not later than June 30, 2005.

RECOMMENDATION #3

IT IS HEREBY RECOMMENDED that other than Section 12, there be no piecemeal approach to legislative reform, rather that there be a comprehensive new Act as set out in Recommendation #2. Nonetheless, **IT IS RECOMMENDED** that Section 12, of the old Act be amended as soon as possible and in any event not later than May 31, 2004, to incorporate the concept of "reasonable and probable grounds" or "reasonable cause" so that a peace officer no longer has to personally observe "a person acting in a disorderly or dangerous manner." This simple amendment will bring Newfoundland and Labrador in line with all the other provinces.

RECOMMENDATION #4

IT IS HEREBY RECOMMENDED that the new Act clarify the criteria for certification under Section 5(1) of the old Act and include the following as contained in the Department of Health and Community Services Submission (DM#7) at page 33:

> a) The person is suffering from a mental disorder as a result of which he or she is in need of care and supervision,
>
> b) Due to mental disorder, the person is unable to fully understand and make an informed decision about the need for treatment, and
>
> c) The person is likely to cause harm to self or others or to suffer substantial mental or physical deterioration if the mental disorder is not treated.

In considering when the involuntary status changes to voluntary, there should be some statutory guidance including the likelihood of following a treatment plan based upon relevant past history.

RECOMMENDATION #5

IT IS HEREBY RECOMMENDED that the new Act clarify the authority to treat an involuntary patient, subject to judicial review (see Recommendation #8).

RECOMMENDATION #6

IT IS HEREBY RECOMMENDED that the new Act contain a provision protecting anyone acting under authority of that Act from civil liability, providing he/she is acting competently and in good faith.

RECOMMENDATION #7

IT IS HEREBY RECOMMENDED that the new Act contain provisions for a community treatment order and conditional leave with appropriate safeguards similar to current provisions in Ontario and Saskatchewan, suitably balancing the rights of the individual with the interest of society. Reference should be made to the text, Canadian Mental Health Law and Policy.

RECOMMENDATION #8

a)**IT IS HEREBY RECOMMENDED** that the Minister of Justice in consultation with the Chief Judge of the Provincial Court of Newfoundland and Labrador establish a Mental Health Division of that Court. This Division would consist of three Judges out of the present complement, appropriately assigned by the Chief Judge for periods of two - four years. One such Judge shall be primarily responsible for the duties set out below with the other two Judges serving as alternates in the event that the primary Judge is unable to act. Without criticism directed at present or past members of the Mental Health Review Board (*Mental Health Act*) or the Review Board (*Criminal Code*), it is felt that judicial leadership is important on both boards to ensure timeliness of review services and be fully capable of addressing key issues including patient rights, confidentiality and release of records; and follow-up on discharge and release programmes. Involvement of a Judge would add to the persuasion aspect of such plans and, where necessary orders could be issued.

b) **IT IS FURTHER RECOMMENDED** that this Division of the Provincial Court of Newfoundland and Labrador sit regularly in an informal manner, non-adversarial insofar as possible, most often not in an established courtroom setting, but in a hospital or other suitable location in the Community.

c) **IT IS FURTHER RECOMMENDED** that the Provincial Review Board be replaced by the primary Judge (or alternate Judge) and that its functions be expanded to encompass as many issues as needed to best serve mentally ill persons, their families, service providers and the public.

d) **IT IS FURTHER RECOMMENDED**, insofar as there are no insurmountable constitutional issues and no amendments required to the *Criminal Code* of Canada, that the primary Judge be appointed chairperson of the Review Board (federal) and that an alternate Judge be appointed to the Board along with a psychiatrist, a psychiatric nurse and a mental health social worker. Again, I would stress the necessity for timely and regular sittings of the Board, informally, most often in a boardroom setting in the Waterford Hospital or other suitable place in the Community.

e) **IT IS FURTHER RECOMMENDED** that Community Treatment Orders be issued by a Judge of the proposed Mental Health Division of the Provincial Court of Newfoundland and Labrador after a hearing, and not be issued by a psychiatrist as in Ontario, Saskatchewan and the draft model of the text.

f) **IT IS FURTHER RECOMMENDED** that a Judge of the proposed Mental Health Division of the Provincial Court of Newfoundland and Labrador may, after a hearing, authorize release of medical information of a mentally ill person, with conditions, to case management teams, family members or law enforcement personnel, if necessary for the safety of the public or the mentally ill person.

g) **IT IS FURTHER RECOMMENDED** that the Mental Health Division of the Provincial Court of Newfoundland and Labrador prepare an annual report to be presented to the House of Assembly. This report will include comprehensive and accurate statistics under the *Mental Health Act*, including admissions to hospital, length of stay, nature of illness, review hearings and results, activities of case management teams and numbers of mentally ill people being served, community treatment orders, etc. - with a view to providing an accurate provincial database which will:

1) assist the Minister of Health and Community Services and the Health Boards to appropriately provide services,

2) keep accurate up to date information for research generally,

3) provide a very real opportunity for close public scrutiny into the use of Community Treatment Orders.

h) **IT IS FURTHER RECOMMENDED** that a Judge of the proposed Mental Health Division of the Provincial Court of Newfoundland and Labrador may, in exceptional cases of geographical remoteness, impassable weather, or peculiar public safety concerns, authorize a brief emergency detention of a mentally ill person in a police lock-up or holding cell. Otherwise, no mentally ill person shall ever be taken to or lodged in a lock-up or police holding cell unless there are reasonable and probable grounds that the person has committed an offence which would justify the arrest and detention.

The Mental Health Division of the Provincial Court would be primarily concerned with the *Mental Health Act* and related services as well as the work of the Federal Review Board. It would be entirely different from Mental Health Courts in Toronto and Saint John, New Brunswick, which proactively and compassionately handle active criminal charges against mentally ill people.

There is precedent for judicial intervention in numerous other jurisdictions including Quebec, New Zealand, Australia, Ohio and other U. S. States.

The proposed Mental Health Division of the Provincial Court of Newfoundland and Labrador should not be a costly initiative. With relatively lower numbers of cases in our

Province, and using the present complement of twenty-five Judges, the only additional cost would be a couple of part-time staff which would be partially offset by the reformation of the Boards.

16.4 Mental Health Services

RECOMMENDATION #9

IT IS HEREBY RECOMMENDED that the Government of Newfoundland and Labrador forthwith provide extra funding to the Health Boards so that services provided to persons with severe and persistent mental illness are co-ordinated through case managers. I am in no position to state a number, but it seems to me that every Board should have at least one person in that role, some smaller boards like Grenfell with one person half time (see above at pages 73 and 74). **IT IS FURTHER RECOMMENDED** that a culture be developed which sees case management as the norm with a paradigm shift away from previous service boundaries and away from crisis intervention to a more proactive approach.

IT IS FURTHER RECOMMENDED that the case manager serve as a formal liaison with the Waterford Hospital so that there are no gaps in follow-up when patients are discharged.

IT IS FURTHER RECOMMENDED that the case manager serve as an informal liaison with consumers and community stakeholders.

RECOMMENDATION #10

IT IS HEREBY RECOMMENDED that the Minister of Health and Community Services develop and implement the provision of mental health services generally on the basis of the principles set out in *Valuing Mental Health* (September 2001) referred to at page 79.

RECOMMENDATION #11

IT IS HEREBY RECOMMENDED that the Assertive Case Management Programme (Stella Burry) in St. John's be continued through adequate funding. **IT IS FURTHER RECOMMENDED** that three other assertive case management models, with no more than ten clients each, be established throughout the Province. The purpose of assertive case management would be to provide intensive supervision to those severely and persistently mentally ill persons whose needs are not met through regular case management. The assertive and regular case manager would also work with the small number of people who may from time to time be subject to a Community Treatment Order.

The format of each case management team will be determined by the regional personnel based on local wisdom and needs. It will, of course, be multi-disciplinary as discussed through the report. In most instances, the manager will be a social worker or a nurse and the team members will be drawn form existing resources.

RECOMMENDATION #12

IT IS HEREBY RECOMMENDED that the Early Psychosis Intervention Programme of the St. John's Health Care Corporation be maintained and expanded as required to meet the needs presented.

IT IS FURTHER RECOMMENDED that the Government of Newfoundland and Labrador make funding available so that over the next three years this type of programme will be available in other regions of the Province. The merits of this programme have been referred to earlier, are sound and are consistent with the wisdom contained in the triangle and elliptical sphere, reproduced earlier at pages 80 and 81.

RECOMMENDATION #13

IT IS HEREBY RECOMMENDED that the Minister of Health and Community Services promote the use of nurse practitioners with extra training in psychiatry to actively serve in those parts of the Province including the Bonavista Peninsula where there is not likely to be a permanent psychiatrist. These specialized nurse practitioners, while not replacing a psychiatrist, would act with the supervision of a psychiatrist with protocols established through ongoing formal liaison between the appropriate bodies.

RECOMMENDATION #14

IT IS HEREBY RECOMMENDED that the Mental Health Crisis Centre operated by the St. John's Regional Health and Community Services Board be continued and that their services, walk-in and telephone, be promoted throughout the entire Province.

IT IS FURTHER RECOMMENDED that the service be expanded to assist police in dealing with crisis situations pertaining to mentally ill persons.

RECOMMENDATION #15

IT IS FURTHER RECOMMENDED that the Regional Health Boards establish mobile health units to respond to mentally ill persons in crisis where no criminal offence is alleged. Each unit would be developed locally and based on local needs.

In the greater St. John's area, a model along the lines of Vancouver's Car 87 or Hamilton's Coast Programme should be developed. In other areas, the models would vary. Intervention would be by experienced mental health workers. Police officers would only be called to assist where the workers determine there is a concern for personal safety.

RECOMMENDATION #16

IT IS HEREBY RECOMMENDED that the Government of Newfoundland and Labrador aggressively pursue, with the Government of Canada, the provision of a significant increase in health funding so that home care services are provided for persons with mental illnesses as spelled out in the Romanow Commission Report.

RECOMMENDATION #17

IT IS HEREBY RECOMMENDED that the Government of Newfoundland and Labrador provide adequate funding for C.H.A.N.N.A.L. so that it can reasonably function as a viable network for self-help groups throughout the Province.

RECOMMENDATION #18

IT IS HEREBY RECOMMENDED that the Government of Newfoundland and Labrador provide a reasonable amount of core funding to the Canadian Mental Health Association, Newfoundland and Labrador Division, over the next four years in addition to funding worthwhile projects on an ongoing basis. I have specifically stated four years as it is fully anticipated that much positive development will be taking place during that time. It is important that the Canadian Mental Health Association in this Province fulfill their many roles including public education, research, and advocacy.

RECOMMENDATION #19

IT IS HEREBY RECOMMENDED that the Minister of Health and Community Services automatically review legislative provisions for Community Treatment Orders if the number of persons at any given time subject to these Orders, exceeds forty.

16.5 Public Education

RECOMMENDATION #20

IT IS HEREBY RECOMMENDED that a comprehensive strategy be implemented with the goal to rid our society of the stigma attached to mental illness.

IT IS FURTHER RECOMMENDED that the Minister of Health and Community Services and the Minister of Education work together to develop and implement a strengthened mental health curriculum to be introduced at the youngest feasible age to all students in the Province.

IT IS FURTHER RECOMMENDED that the Minister of Health and Community Services launch a public education campaign promoting mental health and removing stigma regarding mental illness. **IT IS FURTHER RECOMMENDED** that all citizens avoid all the nasty words too frequently used in reference to mentally ill people, including that the word "schizophrenic" be appropriately used as an adjective and never as a noun. This is not a surface issue of political correctness, rather it is one of tolerance, enlightenment and understanding.

RECOMMENDATION #21

IT IS HEREBY RECOMMENDED that all members of the public refrain from acts of cruelty and indifference to those unfortunate enough to be suffering from mental illness. We were all saddened and disturbed throughout the Inquiry about the taunting and other abuse heaped upon Norman Reid. This is not an indictment solely directed to some citizens of Little Catalina. Regrettably, I have been informed of many similar accounts throughout the Province in my 29 years as a Judge. While this type of insensitivity and cruelty cannot be legislated out of existence, it certainly can be discouraged and condemned.

RECOMMENDATION #22

IT IS HEREBY RECOMMENDED that the Churches, the Canadian Mental Health Association and other organizations encourage their members to befriend, and in some senses take under their wing, persons suffering from mental illness whose lives are often confused and full of despair. There were some citizens of Little Catalina who did help Norman Reid from time to time. Usually, he was able to recognize them and they were not intimidated. Dr. Gallimore, Norman Reid's personal physician from 1978-1987, told the Inquiry of a programme in Quebec where volunteers regularly serve as friends to persons with mental illness. The service is of great assistance to families.

16.6 Accountability

RECOMMENDATION #23

IT IS HEREBY RECOMMENDED that the Minister of Health and Community Services report to the House of Assembly at least once per year in October or November 2004, 2005, 2006 and 2007, as to Government's response to the recommendations of these Judicial Inquiries.

16.7 R.C.M.P.

In submissions, some counsel objected to my making any recommendations pertaining to the R.C.M.P. as it is a federal force under federal control.

Reference was made to *Quebec (Attorney General) v. Canada (Attorney General)* 1979, 1 S.C.R. 218 in which Pigeon J. wrote at pp 20-21.

> Parliament's authority [under the Constitution Act, 1867] for the establishment of this force and its management as part of the Government of Canada is unquestioned. It is therefore clear that no provincial authority may intrude into its management. ... provincial authorities ... cannot, under the guise of carrying on such investigations, pursue the Inquiry into the administration and management of the force.

Provincial law requires me to inquire into the sudden death of Norman Reid and to make a written report to the Attorney General of Newfoundland and Labrador. While the report "may contain recommendations as to the prevention of similar deaths," this aspect has become increasingly important and is generally viewed as the most meaningful part of the process.

Provincial law in no way caused this Inquiry to examine the administration of management of the R.C.M.P.. The R.C.M.P. were cooperative throughout the Inquiry and was very keen to provide detailed information and documentation in many areas including major case management, training modules, use of force, etc. The only information not forthcoming related to the personnel files of the incident officers, which was the subject of a ruling on October 10, 2001, which agreed with the R.C.M.P. position.

During the Inquiry, in which the R.C.M.P. and its three incident officers were quite capably represented, there was absolutely no "guise of carrying on such investigations ... into the administration and management of the force."

Counsel for Constable Malinay stated:

> "All training is good. More training is better. Good training is expensive. Police officers, as well as other health professionals and those who must respond to emergencies which may in any way involve the person suffering from mental illness can benefit from a greater understanding of the various disorders and how best to relate to those requiring assistance. Every officer who testified at both inquiries acknowledged that benefits would be gained from further training in this area.[64]

Clearly there is an acknowledgment that training in this area is improving. Is it really an intrusion into federal jurisdiction to encourage improved training and programmes in the future? It appears times have changed considerably since 1979, and the constitutional friction that existed has diminished.

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[64] Mark Pike, Q. C., Inquiry Brief, Vol. 1, Part III, at 12.

In his letter to Dr. James Young, Chief Coroner for Ontario, dated August 1994, The Honourable Herb Gray, Solicitor General of Canada wrote as follows:

> "Thank you for your letter of July 14, 1994, and the enclosed materials pertaining to the inquest into the shooting death of Lester Donaldson, which involved the Metropolitan Toronto Police Department. As this matter pertains to mental health legislation and police training and operations in the Province of Ontario, it is beyond my direct area of responsibility.
>
> I wrote that a copy of this material was sent to the Royal Canadian Mounted Police (R.C.M.P.). I expect that the Force, particularly in light of its contract role in all provinces and territories, save Ontario and Quebec, will find the recommendations of the Coroner's Jury instructive.
>
> I commend you and the Ministry for undertaking to address this important issue with a view to implementing an improved, integrated response to pre-crisis situations."

Again given the keen participation of the R.C.M.P. in this Inquiry and their high degree of cooperation, I fail to see how they would seek to avoid being subject of provincial recommendations. Indeed the Force may "find the recommendations ... instructive."

Quite properly, the R.C.M.P. greatly assisted the mandate of the Inquiry. It is in that spirit of cooperation and with a view to making meaningful recommendations to help prevent future tragedies in this Province that I am taking the responsibility of making the following five recommendations.

RECOMMENDATION #24

IT IS HEREBY RECOMMENDED that the R.C.M.P. "B" Division, within 12 months of the release of this report, provide a one day seminar to all its members in the Province, to be held at various locations and to include the following subjects:

1) this report,
2) a minimum one hour presentation highlighting the most recently developed R.C.M.P. training on mental illness and appropriate police response,
3) current *Mental Health Act* issues,
4) the status of all R.C.M.P. agreements with various Health Boards in the Province (ex. Grenfell, Grand Falls-Windsor) pertaining to the apprehension and transport of mentally ill persons, and
5) updates in Taser training and deployment.

This seminar would serve as a comprehensive debriefing on the sudden death of Norman Reid.

RECOMMENDATION #25

IT IS HEREBY RECOMMENDED that the R.C.M.P. "B" Division, within 12 months of the release of this report, make every effort to enter into agreements, such as the Memorandum of Understanding with Grenfell Regional Health Services (July 12, 2002) and Central West Health Corp. (February 27, 2002) pertaining to the apprehension of mentally ill persons in crisis, with all Health Boards in the areas of the Province where the R.C.M.P. is primarily responsible for law enforcement.

RECOMMENDATION #26

IT IS HEREBY RECOMMENDED that the Minister of Justice enter into an agreement with the R.C.M.P., through contractual provision or otherwise, for the engagement of an outside police force, such as the Ontario Provincial Police to investigate any future death of any person caused by an R.C.M.P. member in the execution of his/her duties. As indicated above, this recommendation has nothing to do with R.C.M.P. competence or professionalism. It has everything to do with public perception and would provide a consistent approach throughout the Province in the event that such a future tragedy arises. A similar protocol as has been developed with the Royal Newfoundland Constabulary, should be put into effect.

RECOMMENDATION #27

IT IS HEREBY RECOMMENDED that the R.C.M.P. "B" Division actively participate in future consultations in relation to a new *Mental Health Act* and the provision of mental health services throughout the Province and that the Minster of Health and Community Services invite them to do so.

RECOMMENDATION #28

IT IS HEREBY RECOMMENDED that the R.C.M.P. develop a policy which will provide for an entry on CPIC for individuals on whom OC spray has little or no effect.

16.8 Other

RECOMMENDATION #29

IT IS HEREBY RECOMMENDED that the *Fatalities Investigations Act*, SNL 1995, c.F-6.1, Section 5, be amended by replacing the word "immediately" with "forthwith or as soon as practicable" or something similar.

16.9 R.N.C.

RECOMMENDATION #30

IT IS HEREBY RECOMMENDED that the R.N.C. make available one digital cell phone for each police car being used on patrol.

RECOMMENDATION #31

IT IS HEREBY RECOMMENDED that the R.N.C. replace the long batons, presently in use, with collapsible batons.

RECOMMENDATION #32

IT IS HEREBY RECOMMENDED that the R.N.C. training programme for dealing with mentally ill persons be fully developed and put in place no later than June 30, 2004 and that the necessary time and resources be made available to the person responsible for its development to complete this work accordingly.

RECOMMENDATION #33

IT IS HEREBY RECOMMENDED that the R.N.C. acquire a minimum number of Tasers so that training can commence no later than June 30, 2004, with a view to having trained and equipped personnel in each region served by the R.N.C. in the 2004-5 fiscal year; thereafter a timetable to be developed so that adequate equipment and trained personnel are available as required.

RECOMMENDATIONS #34

IT IS HEREBY RECOMMENDED that the R.N.C., within 12 months of the release of this report, provide a one day seminar to all its members, the seminar to be held at various locations and to include the following subjects:

1) this report;

2) a minimum one hour presentation highlighting the most recently developed R.N.C. training on mental illness and appropriate police response;

3) current Mental Health Act issues;

4) the status of all R.N.C. agreements with various Health Boards in the province pertaining to the apprehension and transport of mentally ill persons; and

5) updates in Taser training and deployment.

This seminar would serve as a comprehensive debriefing on the sudden death of Darryl Power.

RECOMMENDATION #35

IT IS HEREBY RECOMMENDED that the R.N.C. amend its Policy and Procedure Manual to ensure that in major incidents, such as police shooting, that:

(i) incident officers are clearly defined;

(ii) incident officers are removed from the scene as soon as possible;

(iii) incident officers are provided with all necessary counselling and reasonable time away from active duty;

(iv) incident officers not be alone together until full statements are taken, unless in the presence of a third party such as a counsellor or member of the clergy; and

(v) an incident officer never be the person required to notify family members of the death.

RECOMMENDATION #36

IT IS HEREBY RECOMMENDED that the R.N.C. develop an organized comprehensive database, consistent with principles of patient confidentiality, so that relevant, important information for its members is made available when dealing with mentally ill persons who are dangerous.

RECOMMENDATION #37

IT IS HEREBY RECOMMENDED that the R.N.C. actively participate in future consultations in relation to a new *Mental Health Act* and the provision of mental health services throughout the Province and that the Minster of Health and Community Services invite them to do so.

16.10 Western Health Care Corporation

RECOMMENDATION #38

IT IS HEREBY RECOMMENDED that Western Memorial Regional Hospital develop policies which will significantly reduce or eliminate the time that police, who are escorting mentally ill patients, spend in the Emergency Department. Procedures to be considered would include a direct escort to the Therapeutic Quiet Room or the Psychiatry Ward or having a designated nurse from the Psychiatry Unit available at all times for call to the Emergency Department.

This recommendation is not to be interpreted in any way as to undermine any programme in St. John's where there is a mental health triage nurse in the Emergency Department.

RECOMMENDATION #39

IT IS HEREBY RECOMMENDED that the same staff member in the Ambulance or Emergency Department of hospitals who receives a call for assistance, which must be referred to the police, be the same staff member who calls the police.

Though there was no evidence of any harm done by a nurse calling the police where the call for help was taken by an ambulance attendant, it would be better for the staff member taking the call to actually phone the police themselves. This will increase the certainty of accurate information being passed on to the police and also that the call receiver can directly respond to any police questions for further details.

Given other more pressing needs of the healthcare system, the Inquiry is not recommending that Emergency or Ambulance Departments at Western Memorial Regional Hospital install equipment to record all incoming calls.

16.11 Transport of Mentally Ill Persons

RECOMMENDATION #40

IT IS HEREBY RECOMMENDED that the Government of Newfoundland and Labrador, review the policy of police transport of mentally ill persons to and from the Waterford Hospital and other health centres and that other agencies such as Hospital Security or Deputy Sheriffs be considered with a view to reducing stigma and easing pressure on police resources.

APPENDICES